EVENT REPORT FORM

Project title	Strengthening Capacities for Higher Education of Pain Medicine in Western Balkan countries
Project acronym	HEPMP
Project reference number	585927-EPP-1-2017-1-RS-EPPKA2-CBHE-JP
Coordinator	University of Belgrade
Project start date	October 15, 2017
Project duration	36 months

Event	Florence Meeting
Type of event	Training of trainees
Venue	Florence
Date	13-17 Sep 2018
Organizer	University of Florence
Reporting date	Sep 17th 2018
Report author(s)	G. Villa, I. Lanini, A. R. De Gaudio

Project number: 585927-EPP-1-2017-1-RS-EPPKA2-CBHE-JP (2017 – 3109 / 001 – 001)

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EVENT DESCRIPTION
with special reference to goals and outcomes

Number of participants at the event	24
Participants (organisations)	UB, UK, UT, UBL, UP, UF, ULJ, UR, UHDM
Event description: Florence Meeting	

Objective of the meeting

This is the third meeting organized in a Programme Country of the project entitled: Strengthening Capacities for Higher Education of Pain Medicine in Western Balkan Countries (HEPMP).

The main objective of this meeting was to introduce the highest academic and clinical offert that University of Florence has in terms of Pain Therapy. With 126 Degree courses organized in 10 Schools, with a population of about 51.000 enrolled students, the School of Medicine is the responsible for the training, assessment, practice and continuing professional development of specialist medical practitioners in the management of pain. It supports a multi-disciplinary approach to pain management, with the Pain Medicine Unit existing since 1970, as well as Postgraduate school in Anesthesiology, Intensive Care and Pain therapy. The Careggi Teaching Hospital cooperates together with the University of Florence, providing care for more than 3.500 outpatients with acute, chronic, and cancer pain problems. They have “Hub and Spoke” model where patients are treated with complex assistance. This model ensures the continuity of care of the patient from the hospital to their home, including the whole set of health care facilities and professionals dedicated to supply palliative care and pain control at all stages of the disease and for any type of patient.

Description of the meeting

Globally, during the entire 5 days, the meeting in Florence presented the university activities on pain therapy activated in the curriculum of the medical university student. Were thus discussed the specialist topics that expert algologists treat during the 5-year specialization in Anesthesia. The lessons concern both pharmacological subjects, invasive and non-invasive procedures addressed to the cancer patient, not oncological inpatients and frail outpatients.

After the Registration, Dr. Rocco Domenico Mediati, Director of the pain therapy center of the University Hospital of Careggi of Florence, spoke to the contents of the thematic areas and internship activities in the hospital wards where students can train themselves to the detection and treatment of pain.
The dott. Mediati then explained how the Masters in Pain Therapy and Palliative Care are organized, their duration, the specialists they are addressed to and the professional opportunities that these two masters offer. Furthermore, Dr. Mediati addressed the topic of the structure and organization of active pain therapy centers in Tuscany. He explained the population of patients he takes care of, the relationship with the medical specialties (oncology / hematology, neurology, surgery, internal medicine) both as counseling activities in the departments and as taking care of patients in the clinic. In particular, Dr. Mediati presented the "hub & spoke" organization as a distinction between specialized

centers and smaller operating units where they carry out consultancy and out-patient activities only. The national documents on chronic pain control, indications on the use of opiates and the use of various devices to control non-onocologic pain were presented. Dr. Mediati has also dealt with the issue of end-of-life pathways in hospitals also in the relationship with the territory, with general practitioners and hospices. He presented the organizational difficulties (number of patients assisted), the detail of palliative care requests within the hospital in Florence and the lack of a specialized training course in pain therapy and palliative care. We have also held a debate on ethical issues about hospitalization and treatment of some patients in advanced stages of home-related illness. Finally, we discussed the university courses in the organization of the masters and lessons on pain therapy in the schools of specialization in anesthesia.

Other specific topics have been discussed in details during the meeting organized in Florence.

Dr. De Cesaris analyzed the organization for the cefalea treatment in the University of Florence and at the teaching hospital of Florence. After an initial presentation of the major forms of headache, a careful classification of the cefalea has been presented, as well as the basis of treatment for the most common forms of cefalea. After this introduction, the main clinical and academic patterns associated with this peculiar form of chronic pain have been illustrated. Regarding the clinical pathways, the following items have been strictly explained:

1. How a patient arrive to the clinical center of Cefalea in Florence.
2. Which are the main specialists that sent the patient to the cefalea center
3. How a tight follow up is performed

Regarding the academic pathways, the following items have been explained.

1. How many curses on headache/cefalea are present in this moment ad the university of Florence in the medical school, specialization schools and in master.
2. Which are the main topics used
3. Which should be the main health care professionals formed for headache/cefalea

Dr. De Cesaris proposed the theoretical distinction between headache and migraine in physiological terms and also as a framework for the person and the therapeutic path to be proposed. We talked about the importance of radiology to reach a precise diagnosis and to help the patient to have knowledge and awareness of his illness. Headache has been recognized as a severe and frequent "social disease". It often seems that patients with headache have a halo of originality in talking about their symptoms, in the intensity of pain (often high) and also in

the low efficacy of many treatments (especially pharmacological). Dr. De Cesaris also mentioned the many non-pharmacological therapies that patients use in hopes of controlling and limiting their pains that limit their lives. He also recounted the contacts that the doctors of the headache center of a hospital maintain with their own pg to try to follow together the evolution of pain, its manifestations and also the correct intake of drugs.
The headache center of the hospital of Careggi provides a first visit of knowledge and classification of the patient, the activation of the radiology and the necessary blood tests, a medical re-evaluation, possible specialist consultations and the prescription of drugs. At the end of the prescription drug visit, an appointment is immediately established as the first follow-up and also other dates to maintain the connection with the patient over time and to be a present reference for his illness (even by telephone if necessary). One topic that Dr. De Cesaris specifically addressed was that of adolescents, who also bring their nutritional, sexual, relational, and "professional" problems into their clinic, which in his experience seem to have great effectiveness in 'raise and lower the pain threshold. Dr De Cesaris also says that it has the impression that in these cases the time of the visits (interview) and the relationship established with the patients can definitely strengthen the therapeutic adherence and also the maintenance of the visits that the patients over time (years) do in the surgery.

In a second session, Dr.ssa Baronio and Dr Michelagnoli explained the Invasive pain management techniques performed in peripheral (not University) centers in Tuscany. A multitude of invasive pain management therapies have been described to treat neck and back pain and its involve injections or placement of device into the body.

Dr Michelagnoli speaks about the most common procedure performed in his peripheral not university center, i.e. the spinal cord stimulation (SCS), and the types of pain that can be treated with this procedure. In particular, the types of pain that is not responsive to treatment and is not due to cancer have been explained, and among these, the Failed back surgery syndrome (FBSS) – continued pain after back surgery [Complex regional pain syndrome (CRPS) – condition where there is pain, swelling and difficulties with movement in the limbs; Extremity pain due to peripheral neuropathy (failure of the nerves carrying information to the brain and spinal cord causing pain, sensory problems and problems with movement), root injury and phantom limb pain (pain in an already amputated arm or leg, as if it were still there); Pain due to lack of blood supply in a limb, usually due to diseased blood vessels supplying the limb]

The main benefits of Neurostimulation Therapy Treatment have been thus recognized, and mainly its possibility to replace the pain signals with a soothing, tingling sensation (paresthesia); Furthermore, several

advantages have been described, such as:

- Reversible trial is completed for three to seven days to determine effectiveness of therapy;
- Outpatient procedure with little recovery time;
- Ability to sit, walk and stand for longer periods;
- Reversible system can be removed at any time;
- Reduces need for oral medications;
- Patient-controlled programming allows for customized pain relief.

Also Dr. Baronio reported her experience on high-level pain therapy performed in a not university center. She spoke about the stages required for the implantation SCS's procedure: the first, where the lead is implanted for a trial of the therapy which may last between 1 and 10 days,and the second where the complete neurostimulation system is implanted following the trial period. Dr Baronio described also the clinical pathway that her center has adopted to identify and manage conditions where the use of SCS is not recommended (e.g. infection near the spine, an infection that affects the whole body, bleeding disorders, scarring the the part of the spine where the wires are placed, patients with cardiac pacemakers).

A discussion with all HEPMP's participants initiated in order to share experience on SCS's use, protocols and teaching strategies.

Invasive analgesic therapies have been recognized by the panel as an important alternative to medical management of chronic pain. Most of them ensure a pain relief lasting for several days or even years. Their main goal is to reduce pain allowing the restoration of normal activities and a physical therapy program. As an example, the epidural steroid injection (ESI) is a minimally invasive procedure that can help relieve neck, arm, back, and leg pain caused by inflamed spinal nerves due to spinal stenosis or disc herniation. Dr. Michelagnoli explained the patients who, in his center, are candidates to epidural steroid injection (ESI),i.e. those with spinal stenosis (a narrowing of the spinal canal and nerve root canal can cause back and leg pain, especially when walking), spondylolisthesis (a weakness or fracture between the upper and lower facets of a vertebra), herniated disc (the gel-like material within the disc can bulge or rupture through a weak area in the surrounding wall; irritation, pain, and swelling occur when this material squeezes out and comes in contact with a spinal nerve), degenerative disc (a breakdown or aging of the intervertebral disc causing collapse of the disc space, tears in the annulus, and growth of bone spurs), sciatica (pain that courses along the sciatic nerve in the buttocks and down the legs. It is usually caused by compression of the 5th lumbar or 1st sacral spinal nerve).

The experience of dr. Michelagnoli it's some pain relief benefits from ESI. For those who experience only mild pain relief, one to two more injections may be performed, usually in 1-4 week intervals, to achieve

full effect. Duration of pain relief varies, lasting for weeks or years. Injections are done in conjunction with a physical therapy and/or home exercise program to strengthen the back muscles and prevent future pain episodes.
With Dr. Baronio the HEPMP delegates also discussed about two others invasive techniques in chronic pain management. The first one was the "Lumbar sympathetic nerve block", i.e. a relatively safe procedure with minimal risk of complications. During this minimally invasive procedure, an anesthetic agent (lidocaine or bupivacaine) is injected. In some cases a corticosteroid (betamethasone, triamcinolone, or dexamethasone) can also be injected. The medications are delivered to the sympathetic ganglia that lie adjacent to the L2, L3, and L4 vertebrae. The numbing agent can provide pain relief, while the corticosteroid can reduce inflammation. Dr. Michelagnoli showed a tutorial video, used for academic and teaching purpose, about the procedure about Lumbar sympathetic nerve block. These injections are often performed under fluoroscopic (x-ray) guidance. Local anesthetic is placed near to the lumbar sympathetic chain in order to relieve the pain. The injection is done from the back, in the lower aspect of the back. A needle is placed, often under x-ray guidance, to a spot just to the side and approaching the front part of the spine where the ganglion is located. If it is done under x-ray, a small amount of dye is injected to make sure the needle is in the right place. The risks of a lumbar sympathetic block have been recognized, including bleeding, infection, allergic reaction, nerve damage, paralysis, a drop in blood pressure, anesthetic toxicity, hematuria (blood in the urine), numbness, weakness, and medication side effects.

The second technique discussed was the "Celiac Plexus Block". In this case, a needle is placed via your back that deposits anesthetic drugs to the area of a group of nerves called the celiac plexus. This injection is often performed as a diagnostic injection to see whether a more permanent injection may help with the pain. If it provides significant pain relief then the more long lasting injection may be done. This injection is usually performed under x-ray guidance. The needle is placed via the mid back and placed just in front of the spine. Contrast dye is injected to confirm that the needle is in the right spot; followed by some numbing medicine.

Beyond these specialistic medical procedures, the panel discussion was also enriched with other multidisciplinary perspective. Dr. Mery Paroli was involved in the discussion; she is Psychologist to University of Pisa and engaged in the activities of the Pain Therapy Center of the University Hospital of Pisa. During her lecture, the context of implantology was framed in the patient with chronic pain with particular reference to the process of psychological screening in its various phases of patient assessment. The proposed screening is part of a multidisciplinary process involving the doctors participating in the intervention, the organ specialists and during the visit also the family

members.
Psychological screening also serves to make the psychologist meet with the patient for any interviews following the patient's implant. In the Dr.Paroli's center, after screening, the psychologist writes a report also by administering and compiling a battery of tests to assess any anxious, depressive symptoms or to rule out suspicions of a psychiatric disorder. This will help doctors to evaluate the patient or plan a possible referral of the patient to the implant maybe after psychiatric therapy or psychotherapeutic support.
In this case the psychologist becomes an important referent in the clinical and organizational network to achieve the best control of the person's chronic pain. During this lesson Dr. Paroli also explained the multiple settings of care that the psychologist can follow. We talked about the outpatient activities, the consultations in the ward, the interviews for cancer patients and also the management of databases for the collection of clinical and biographical data. Dr. Paroli at the end of her report also spoke about the importance of group work precisely to exchange patient news and to gather detailed information on the type of pain that makes the person suffer. It is very important (and this also often deepens in psychological interviews) to know precisely what clinical interventions the patient has already undertaken and the degree of therapeutic adherence that the patient maintains. The psychologist with the screening process also tries to understand the relationship that the patient has to drugs and especially to drugs, perhaps even on the basis of past or current dependency experiences

An entire session of the Florentine meeting has been scheduled for frail patients and continuity of care. Several problems have been taken into considerations, from the recognition of the frailty patients requiring chronic pain management to the patients' follow-up. The ACOT team was presented, as well as the programme and clinical pathways used by ACOT. A particular attention has been paid to the multidisciplinary approach for the evaluation and care of these patients and to the importance of a basic academic teaching to make all the different healthcare professionals involved in these pathways aware about problems and possible solutions. The advantages and the drawbacks of this model have been analyzed. In particular, a rapid and multidisciplinary approach has been recognized as the main advantage of this integrated model. On the other hand, the limited compliance and/ or resources of general practitioners are recognized as critical points of this process. The integration from continuity of care, palliative care and pain chronic management of these frail patients has been recognized as a main factor for the good outcome. A tight connection between this program and the previous Erasmus plus project TEMPUS has been recognized.

Dr. Teresa Lunghi lectured on the subject of medicine on initiative. Healthcare initiative means a model of care for chronic diseases that does not wait for the citizen in hospital (waiting health), but "meets"

before the diseases arise or worsen, thus ensuring the patient adequate interventions and differentiated according to the level of risk, also focusing on prevention and education. Healthcare initiative is one of the new health care models of Tuscany: the reference is the Chronic Care Model, which is based on the profitable interaction between the patient (made more informed with appropriate training and training) and doctors, nurses and social and health workers. Healthcare initiative aims at both the prevention and improvement of the management of chronic diseases at every stage and therefore affects all levels of the health system, with positive effects expected both for the health of citizens and for the sustainability of the system itself.
This model has been identified to effectively respond to the aging trend of the Tuscan population (highlighted by epidemiological and demographic studies), which brings with it an increase in the relevance of chronic diseases and the change in the demand for assistance.
The results of the first phase of implementing own-initiative health
The analysis of data for the first four years showed that:
• increase the process and therapy indicators for diabetes and decompensation
• decreases the 4-year mortality among the enlisted
• increases hospitalization in both diseases (due to the emergence of a real need and in general to a greater, but more appropriate, recourse to hospitalization)
• patient satisfaction: two thirds of the interviewed sample report positive perception
• satisfaction of physicians: 45% of general practitioners reported good or excellent satisfaction (scale 4 or 5), while only 6% reported a totally negative judgment.

In the same session, Prof. Mauro Di Bari, head of geriatry in Careggi Hospital and director of the school of specialization in geriatry at the University of Florence, has dealt with the issue of pain control in the elderly patient that due to one or more pathologies or due to the physiological aging process presents various forms of more or less disabling pain. Older people represent a very important proportion among cancer patients and often require specific adaptations of the diagnostic, therapeutic and care pathway with which the disease is dealt with. Among elderly patients, the large elderly (aged> 80 years) affected by cancer, even minority, are a reality more and more manifest, but at the moment still little studied. The assistance and proper care of the elderly person affected by cancer is a priority of the Oncological Plan. The combined effects of the aging of the population and the increase in the diagnosis of tumors in the elderly require greater reflection on the means to be used and coordination between the two great disciplines, Oncology and Geriatrics, which are involved. For this purpose, a transversal interdisciplinary onco-geriatric approach is necessary, obviously with the involvement of the General Practitioner. This oncological and geriatric approach is still underdeveloped and this leads to inadequacies and inequalities in access to services.

With regard to the elderly sick oncology, disabled and / or fragile, the burden of care, particularly in the terminal stages of illness, comes today, in Italy, for the most part supported by the family. The reason for this reality, if on the one hand it is historically to be attributed to the central role of the family in satisfying the needs that arise within it, on the other is due to the fact that the current social and health organization actually offers today inadequate welfare model. Although territorial assistance services represent the most logical proposal for the needs of elderly disabled and / or fragile elderly patients, they are completely lacking: home care does not often provide for real social-health integration and provides discontinuous interventions. The elderly terminal cancer patient needs continuous assistance, designed to provide integrated, global and continuous answers over time. For continuous assistance to be able to achieve the objectives for which it was designed, implemented and tested, it is necessary that the structures and services that compose it are included in a network model, that is in a real assistance circuit that face of the elderly and his family in the continuous development of needs. The focus of this model is an operative team, the so-called geriatric evaluation unit (UVG), composed of the geriatric doctor, the social worker and the geriatric nurse, who are assisted by other professional figures in addition to the general practitioner. according to the different problems and needs of the subject. Unfortunately, this model of assistance for the frail elderly in the terminal stages of the disease, even if it was taken care of by the latest National Health Plans and numerous Regional Health Plans, has so far only partially and partially achieved, even before budget constraints, due to a lack of "culture" in relation to the weaker segment of the population. It is therefore desirable that a highly civilized country as it is certainly our adapt its welfare system to the needs of the frail elderly by overcoming the many resistances and inertias that hinder the realization of a change that can no longer be postponed.

Finally, Prof.ssa Mariella Orsi (philosopher and bioethicist) was involved in talking about the living will in Italy and in particular of the law n.219 on 2017. In December 2017, the Italian Parliament approved a new law on living wills, Law n. 219/2017, known as the Advance Healthcare Directive (DAT). It entered into force on 31 January 2018. Every adult over the age of 18 years old, deemed sound of mind, expecting himself/ herself no longer to be capable of self-determination in the future, may make use of the so-called DAT (disposizioni anticipate di trattamento, the Italian for anticipated instructions for treatment). By filling in the relevant paperwork, a person expresses his/her wishes related to medical treatments, including consent or refusal of artificial hydration and feeding. DATs shall be binding for the doctor unless they are manifestly inappropriate or non-compliant with the patient’s current medical condition or unless some therapies, which could not be predicted or were not known at the time a person signed DATs, become available.

This law gives all adults of full mental capacity in Italy the possibility to formally give indications regarding the medical treatments that they want to receive in case they are no longer able to make that choice at the necessary time because of illness or mental incapacity. Prof. Mariella Orsi exposed that a living will can be drafted in three ways:

- By a handwritten document;
- By filling out a living will form, which is available on the Associazione Luca Coscioni's website (and can be adapted according to individual needs);
- If the person's physical conditions does not allow the living will to be written, it is possible to express one's wishes and needs through a video recording or with technological devices designed for people who have difficulty communicating.

In this way, Italian citizens can write their own advance healthcare directives in case of a future illness. It is always possible modify, revoke and reconfirm it.
The law provides the possibility to nominate a fiduciary: anyone can choose a person (such as a family member) who, thanks to his favored position, can rightly interpret the healthcare directive in light of medical and scientific evolution. It is important to underline the fact that through the living will it is not possible to demand medical treatments that are against the law. This means that the document cannot provide medical treatments that are illegal under Italian law, for example Article 5 of the Civil Code prescribes that it is forbidden to cause the permanent reduction of the person's physical integrity if this is not essential to save the person's life. After writing the biological will, it is possible to convert it into an official record and file it to the public administration, for example the mayor of the city of residence, or to a notary. Also, if the region of residence regulates the collection and the storage of living wills, it is possible to file it to the relevant healthcare facility. Prof.ssa Orsi speaks also about Informed consent. This law on Biotestamento protects a person’s right to life, health, dignity and self-determination and provides that no medical treatment can be started or continued without the patient’s freely given and informed consent. All people have the right to know their health conditions and to receive exhaustive, updated and comprehensible information about the diagnosis, prognosis, benefits and risks of diagnostic tests and of prescribed medical treatments, as well as about the possible alternatives and consequences connected with a possible refusal of treatment. Orsi remember the option about of Possible interruption of artificial feeding and hydration. Every adult, over the age of 18 years old, deemed to be sound of mind, has the right to fully or partially refuse any treatment or to revoke, at any time, the consent he/she gave, even should such a withdrawal of consent entail an interruption of the treatment in question. Feeding and hydration are comparable to medical treatments. It will therefore be possible to request that their administration be

stopped or to refuse them.

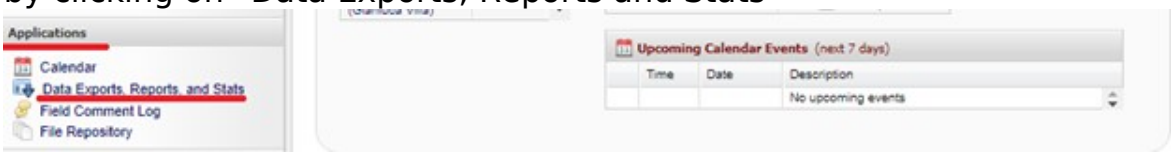
Considering that a wide and interactive discussion raised after each of the scheduled presentations, in accordance with all the attendees, the Board meeting was scheduled on Sunday the 16th of September. Minutes from the Board Meeting will be made available by the Project Coordinator.

A restricted meeting was thus organized on the last day with the local Erasmus Plus office coordinator. Attendees of this meeting were Dr Villa, Prof Stevanovic, Dr. Petričević, Dr Radenković and Dr Ilaria Cavaciocchi (the referee HEPMP at the Erasmus plus office, University of Florence). In this meeting rules for financial reporting, modalities for scientific and financial reports and deadline were clarified. A final agreement was reached between University of Florence and University of Belgrade on this particular topic.

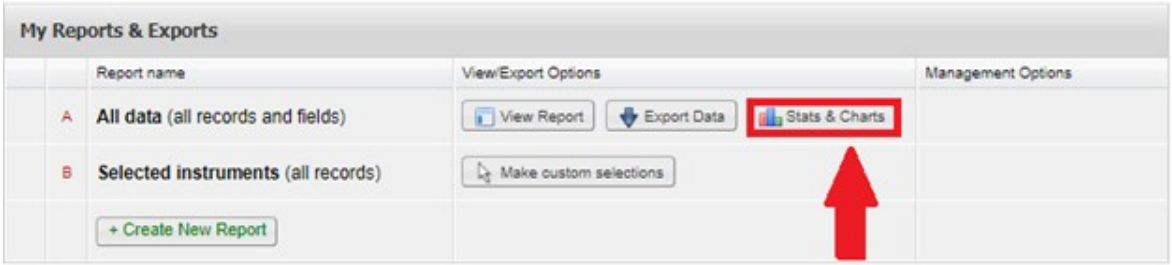
As a final presentation, Dr Villa and Dr Lanini showed parts of reports produced for the Florence meeting. In particular, the “Event evaluation forms” delivered were preliminary analyzed cumulatively, and the “event evaluation calculator” prepared as deliverable for this meeting were shared with all other countries. All other forms prepared by the project coordinator were analyzed with all the attendees, and an agreement was reached on the modality of reporting and the general use of these forms. Finally, a web based platform developed in Florence for the short and long terms monitor of acute pain was presented to the project coordinator and to all the attendee. This web-based platform has been proposed as a “pilot study” for a next deliverable scheduled for HEPMP (a web-based application for chronic pain management).

A preliminary version of the web-based registry has been created to allow the HEPMP project coordinator to make a preliminary evaluation of the selected variables and the potential clinical advantages deriving from the use of this tool. In order to highlight the immediate efficacy for data recording and ease of use that characterize this online platform, a demonstration RedCap® project has been purposely set up.

Depending on the data’s nature, the pain physician will be asked to give single or multiple answers, to insert numerical values or fill in text boxes (e.g. drugs’ names). Each section contains specific items, selected to provide the most relevant clinical information in different phases of renal replacement therapy applied to critically ill patients. Another very useful and relevant function provided by RedCap® is represented by the possibility of an automated statistical analysis of registered data, that can be accessed from the “Application” section of the left-hand column, by clicking on “Data Exports, Reports and Stats”

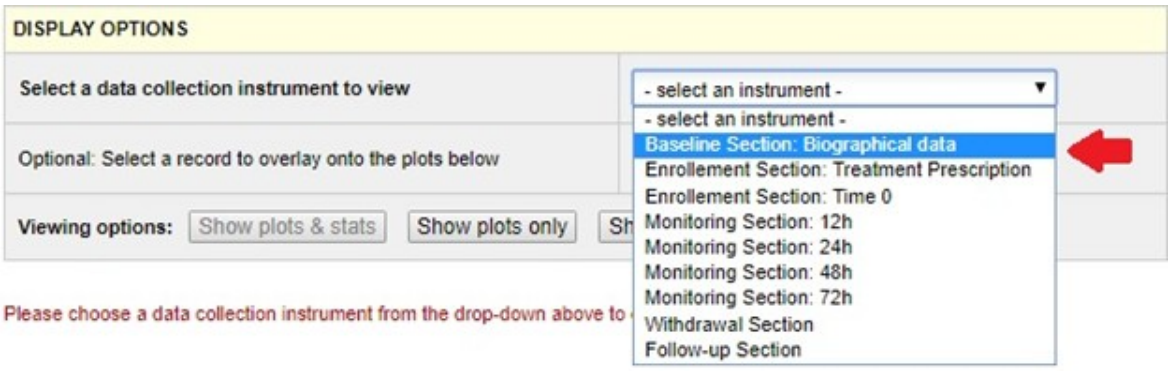


and then on the “Stats & Charts” button.



You can subsequently choose the specific data collection instrument you are interested in and visualize corresponding plots and stats

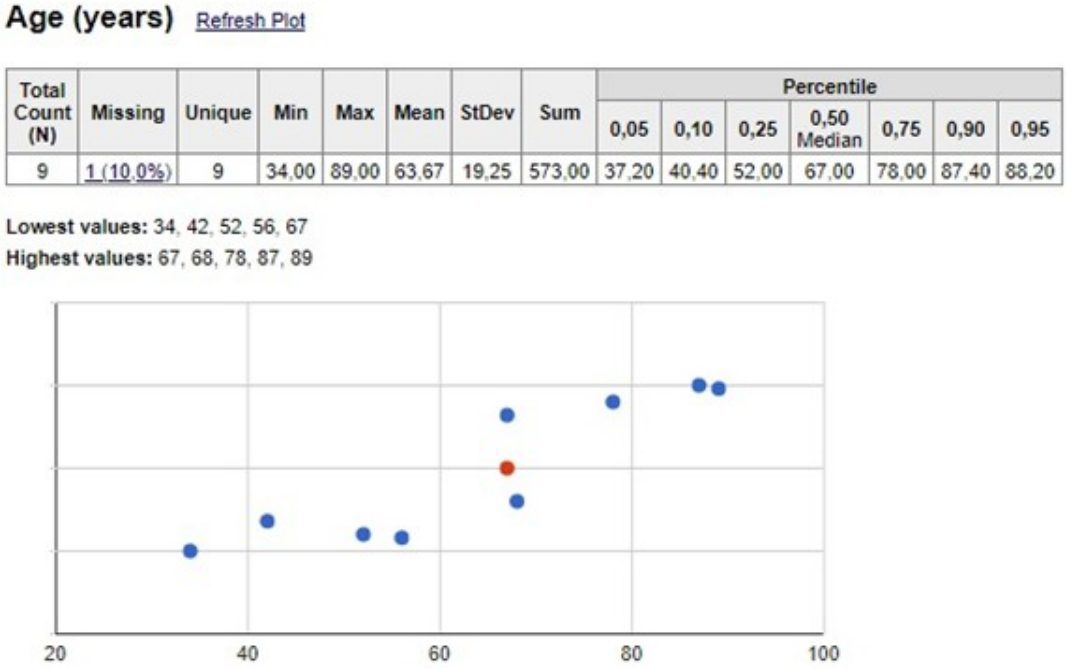
All data (all records and fields)



Please note that this exemplificative project has been set up as a limited part of the research tool that will actually be employed for clinical use; the latter will include a larger number of parameters and sections and will consequently provide wider opportunities for data collection and clinical research. It will also be formulated in every language of each European country in the HEPMP, in order to be more user-friendly.

Notably, as stated elsewhere, several features will distinguish this web-based registry from those already available. In particular, it will be available for smartphone and/or tablet applications in both in-line and off-line modalities; it will provide clinical tools for the treating physician (e.g. instantaneous and automatic calculation of ideal body weight and tools for drugs posologies),

as well as basic real-time statistical reporting for all variables recorded.



All these characteristics will contribute to the widespread use of this easy-to-use web tool, obtaining a large database of patients with highly variable clinical features.

The meeting was closed with the final discussions and planning of the future activities. Prof. Dr. Predrag Stevanovic and Prof De Gaudio thanked everyone for participating and helping this kick-off meeting to be successfully achieving all the listed objectives.

Attachments

Agenda (pdf)	Annex A, HEPMP Florence meeting agenda
Attendance sheet (pdf)	Annex B, Florence meeting attendance sheets
Photos (jpg)	Annex C, photos
Deliverable (pdf)	Annex D, event evaluation calculator Annex E Florence meeting evaluation summary
Presentations (pdf)	Presentations
Other personal remarks	

Organisation details

Invitation sent to	Al Coordinators
Date of event material release	02.09.2018
Date of participants list's finalisation	12.09.2018
Date of agenda finalisation	12.09.2018
Number of participants (according to the participants list)	
Comments	
Results for organization details have been summarized from data reported on the "Quantitative / Qualitative Monitoring Questionnaire". Most of attendees were Satisfied/very-satisfied with the coordination of the project and with the overall animation of the partnership. All the attendees were Satisfied/very-satisfied with the circulation of the information between the partners and the frequency declared for contacts among partners of the project was "every 30 days". Formal written communication/by mail was recognized as the most operative instruments to communicate the activities of the project. Interestingly, During the project, "few-enough" difficulties have been described within the partnership. Most of them, are reported to the lack of an Erasmus plus office at the local institution. Up to 75% of the attendees recognized that the project allowed the Partner to share and enrich their experiences. Furthermore, the exchange of knowledge and new information convinced the partnership to create opportunities for new collaborations in future.	

Problems encountered during the event preparation phase

Please add your comments, if any:

Strengths and limitations of the event (please include comments received)

Strengths of the event and contributions or activities by participants	
Suggestions for the improvement	
Any further comments	

Evaluation details

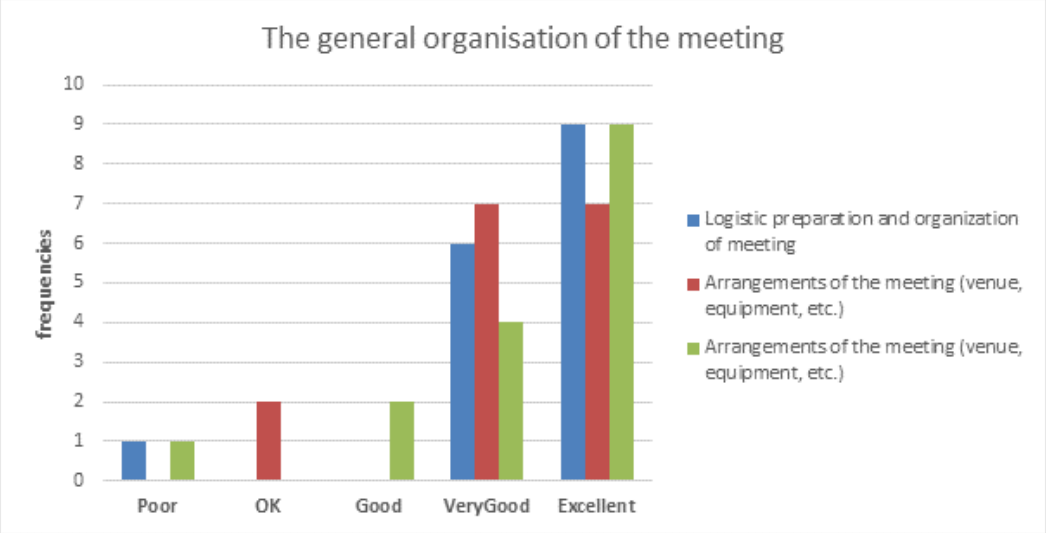
Results of evaluation of the general organisation of the event

Description
In the last day of the Florence meeting, the "Event Evaluation List" was delivered to all the attendees. Among all the forms delivered, 16 returned back. These were collected, scanned to make them available on the website, and the original forms stored at the University of Florence, Erasmus plus office. The evaluations reported in these forms have been transferred into an excel file and analyzed cumulatively, in order to quantify the Attendees' perspective on the general organization of this specific event. Among attendees, only 1 (6.25%) have described a poor quality in at least one item of the form referring to the general organization of the meeting. Two attendees (12.5%) have described an acceptable quality (OK or Good) in at least one item of the form referring to the general organization. Most of the attendees (13, 81.25%) have described a high level of quality (very good-excellent) in all the items of the form referring to the general organization of the Florence meeting. Unfortunately, no additional comments were available that might allow the meeting coordinator to better understand the reason for a poor or only acceptable answers. A specific meeting with all the local project team members has been organized on the last day of the meeting to identify the potential pitfalls in the organization systems. Certainly, the lack of a specific budget in the Erasmus plus financial plan for the organization can be recognized as a potential drawback. As an example, other money funds available for the University of Florence were used to guarantee food and drink for all the attendees during the meeting. With these limited funds, no professional catering service was involved, and the lack of vegetarian food has been recognized by several attendees as a limit in the organization. Furthermore, the lack of budget for the organization of the meeting does not allow the organizer to schedule meeting classes available at the University of Florence for rent. The venue, pieces and type of equipment were those available for the project team members didactic purposes.

Table(s)/Figure(s)

	Poor	OK	Good	Very Good	Excellent
The general organisation of the meeting					
Logistic preparation and organization of meeting	1	0	0	6	9
Content of the Agenda	0	2	0	7	7
Arrangements of the meeting (venue, equipment, etc.)	1	0	2	4	9

Frequencies of answere for each specific items of the "general organization" section.



Results of evaluation of general working communication

Description

In the last day of the Florence meeting, the "Event Evaluation List" was delivered to all the attendees. Among all the forms delivered, 16 returned back. These were collected, scanned to make them available on the website, and the original forms stored at the University of Florence, Erasmus plus office.

The evaluations reported in these forms have been transferred into an excel file and analyzed cumulatively, in order to quantify the Attendees' perspective on the

general working communication of this specific event.

Among attendees, only 1 (6.25%) have described a poor quality in at least one item of the form referring to the general working communication of the meeting. Four attendees (25%) have described an acceptable quality (OK or Good) in at least one item of the form referring to the general working communication. Most of the attendees (11, 68.75%) have described a high level of quality (very good-excellent) in all the items of the form referring to the general working communication of the Florence meeting.

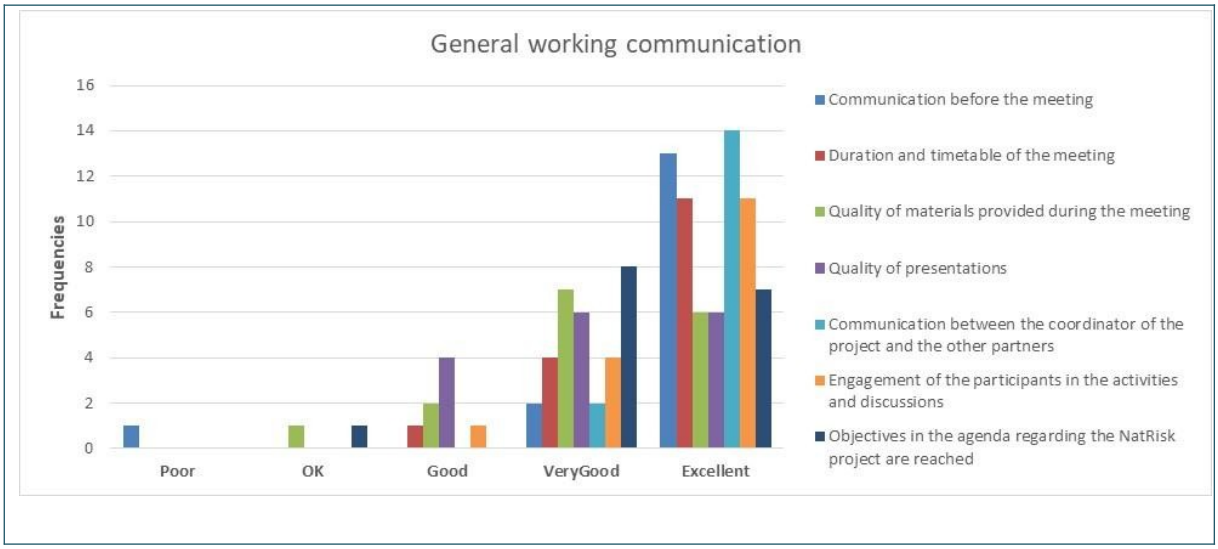
Unfortunately, no additional comments were available that might allow the meeting coordinator to better understand the reason for a poor or only acceptable answers.

A specific meeting with all the local project team members has been organized on the last day of the meeting to identify the potential pitfalls in the general working communication system.

Table(s)/Figure(s)

	Poor	OK	Good	Very Good	Excellent
General working communication					
Communication before the meeting	1	0	0	2	13
Duration and timetable of the meeting	0	0	1	4	11
Quality of materials provided during the meeting	0	1	2	7	6
Quality of presentations	0	0	4	6	6
Communication between the coordinator of the project and the other partners	0	0	0	2	14
Engagement of the participants in the activities and discussions	0	0	1	4	11
Objectives in the agenda regarding the HEPMP project are reached	0	1	0	8	7

Frequencies of answere for each specific items of the "general working organization" section



Results of evaluation of overall success of the event

Description

In the last day of the Florence meeting, the "Event Evaluation List" was delivered to all the attendees. Among all the forms delivered, 16 returned back. These were collected, scanned to make them available on the website, and the original forms stored at the University of Florence, Erasmus plus office.

The evaluations reported in these forms have been transferred into an excel file and analyzed cumulatively, in order to quantify the Attendees' perspective on the overall success of this specific event.

Among attendees, only 1 (6.25%) have described an acceptable quality (OK or Good) in at least one item of the form referring to the overall success of the event. Most of the attendees (15, 93.75%) have described a high level of satisfaction (very good-excellent) in all the items of the form referring to the overall success of the Florence meeting.

Table(s)/Figure(s)

	Poor	OK	Good	VeryGood	Excellent
Overall success of the meeting					
Mode of reaching the decisions at the meeting	0	0	1	6	9

Opportunities to express your opinion and influence decisions	0	0	2	5	9
Achievement of the meeting and project goals	0	0	0	9	7
Discussion of tasks for the upcoming activities and meetings	0	0	1	4	11
Assignment of follow-up tasks	0	0	1	5	10

Frequencies of answere for each specific items of the "overall success of the meeting" section

Please indicate your suggestions for further event's improvement:

_____
_____
_____
_____
_____
_____
_____

Location, date

Florence 30.09.2018

Signature