Grundtvig Learning Partnerships
2013-1-RO1-GRU06-29473 1

Lifelong Learning Programme

MUTUAL CARING - FROM KNOWLEDGE TO ACTION

Educational challenges in social and medical care – disability care
19/09/2014, Riga, Latvia

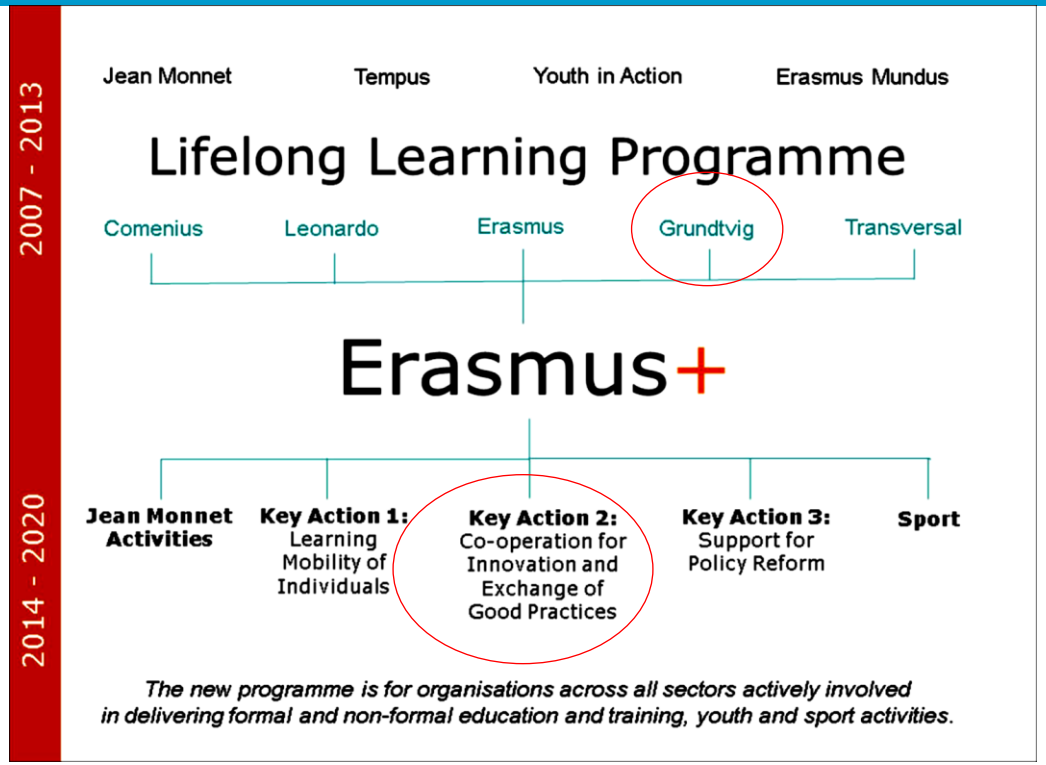
WHAT IS A GRUNDTVIG PARTNERSHIP?

Grundtvig Partnerships
(also known as *Grundtvig Learning Partnerships*) *were
small-scale cooperation projects
between institutions working in the field of adult education, which decide to work together on one or more topics of common interest.

The focus is on
the exchange of ideas and best practice between different organizations across Europe.

former LLP, replaced now by the **ERASMUS+ Programme: KA2 Cooperation for innovation and the exchange of good practices - **Strategic Partnerships** (mono-sectoral or cross-sectoral, decentralized action)*

Innovation is **the most important principle** of KA2 **Strategic Partnerships.**



An **innovative and/or complementary project** can be interpreted in a broad sense:

- new or additional **needs** addressed;
- new or additional **products or educational practices** shared or developed;
- new or additional receiving **countries, target groups or sectors**;
- new or additional **methods** for **delivering innovation** or **sharing approaches**.

M-CARE
The Partnership

UNIVERSITY OF CRAIOVA, DEPARTMENT OF PHYSICAL THERAPY AND SPORTS MEDICINE, FACULTY OF PHYSICAL EDUCATION AND SPORT, ROMANIA

GENERAL DIRECTORATE OF SOCIAL ASSISTANCE AND CHILD PROTECTION DOLJ, ROMANIA

TOR VERGATA UNIVERSITY OF ROME: FACULTY OF MEDICINE, CLINICAL SCIENCES AND TRANSLATIONAL MEDICINE DEPARTMENT, ITALY

EUROPEAN EDUCATIONAL CIRCLE, LATVIA

THE CRACOW CENTRE OF MANAGEMENT AND ADMINISTRATION LTD, POLAND

2-year Lifelong learning Grundtvig project for unpaid and professional caregivers, chronically ill or disabled patients.
AUGUST 2013 – JULY 2015

UNIVERSITY OF CRAIOVA ROMANIA

The University of Craiova was founded within the university center system in Romania in the second half of the 20th century, being, chronologically, the fifth university in the country, following the ones in Iasi, Bucharest, Cluj-Napoca, and Timisoara.

UNIVERSITY OF CRAIOVA

- **It includes also the Faculty of Physical Education, Sport and Physical Therapy that prepares future specialists in sport performance, sports training and rehabilitation.**
- **Most of professors of this faculty are sports medicine physicians and rehabilitation doctors. They have also medical activities in the Sport Medicine Department of Regional Hospital Craiova.**
- **Research centre: "Centre for study of human body motricity": developing research in rehabilitation, physyiology, biomechanics, neuromuscular and neuromotor assessment, sports medicine; recognized and accredited by RO National Research Agency with national and international research programes, including FP7.**

M-CARE
The idea …

- routines and ways of coping developed by families (through both the caring person and affected person are looking after each other) can provide the basis for an innovative learning approach, in which '**mutual care**' and '**interdependency**' should underlie educational/health topics on disability issues.

How ?

- by supporting, training and raising the educational, social, health knowledge and competencies for patients, families and professional caregivers

- by dissemination/exploitation, every participant becoming a project multiplier

INTRODUCTION
Why this Project? (I)

One in six people in the European Union (EU) **has a disability** that ranges from mild to severe ➡ **87.5 million** who are often prevented from taking part fully in society and economy because of environmental and attitudinal barriers.
For people with disabilities the **rate of poverty is 70 % higher** than the average partly due to limited access to employment.

Europe's society is ageing due to three factors: people are living longer, having fewer children, and those born during the post-war population boom (so-called 'baby-boomers') are reaching retirement age.

The proportion of the **population over the age of 65 in EU** will almost double over the next 50 years, **from 87.5 million in 2010 to 152.6 million in 2060** *(European Commission, The 2012 Ageing Report).*
In the same period, the old age dependency ratio is expected to double.

While there are currently four people of working age (between 15 and 64 years) for every one person aged over 65, by 2060 this ratio will have declined to only two to one, putting greater pressure on society. Although advanced age does not necessarily lead to a need for care, looking at the age profile of the population can help us to predict the **future demand for long term care**.

Why this Project? (II)

One of the greatest challenges that will face health systems globally in the 21st century will be the **increasing burden of disabilities and chronic conditions** (WHO 2002).

Chronic conditions are defined by the World Health Organization (WHO) as requiring **"ongoing management over a period of years or decades"** and ***cover a wide range of health problems that go beyond the conventional definition of chronic illness*** (such as heart disease, diabetes and asthma), but including HIV/AIDS, mental disorders, defined disabilities and impairments.

Major challenges for EU health systems include the continuous care needs of chronic disease patients and the occurrence of multiple diseases (co-morbidity), especially in older patients.

Thus, **optimal management of chronic diseases** is the **key factor for patients, their relatives and for the sustainability of healthcare and social systems.**

Why this Project? (III)

MANAGEMENT OF CHRONIC CONDITIONS

A successful management of chronic conditions require **a motivated and highly skilled workforce**, not only in terms of numbers, but also in terms of roles, tasks and responsibilities.

- **implications for education and training of providers**
- **adjustments of medical training curricula to define new skills to meet the needs of patients with chronic conditions**
- **targeted consultation with major stakeholders**
- **involving patient organizations**
- **exchange of good practices**
- **strengthening the role of the patients**

AN OVERVIEW OF CARE FRAMEWORKS AND MODELS (I)

Care concepts include *(Krumholz et al. 2006)*:

- **"case management",**
- **"coordinated care"**
- **"multidisciplinary care"**

CASE MANAGEMENT

- Has the goal of reducing the use of (unplanned) hospital care through the development of care or treatment plans that are tailored to the needs of the individual patient who is at high risk socially, financially and medically *(Gravelle et al. 2007)* **.**
- **Patients are assigned to a case manager**, often a (specialist) nurse/ social worker, **who oversees and is responsible for coordinating and implementing care** *(Norris et al. 2002).*

AN OVERVIEW OF CARE FRAMEWORKS AND MODELS (II)

MULTIDISCIPLINARY CARE

An “extension” of case management, that also normally involves the development of treatment plans tailored to the medical, psychosocial and financial needs of patients;
But in contrast to case management **utilizes a broader range of medical and social support personnel** (including physicians, nurses, pharmacists, dieticians, social workers and others) **to facilitate transition from inpatient acute care to long-term outpatient management of chronic illness** (Krumholz et al. 2006).

COORDINATED CARE

Involves the development and implementation of a therapeutic plan designed to integrate the efforts of medical and social service providers, often involving designated individuals to manage provider collaboration.

MANAGEMENT OF CHRONIC CONDITIONS

The role of patient/family empowerment in chronic disease management

The informal meeting of the EU Health Ministers in April 2012 ***suggested*** *to start with* ***the exchange of experiences and the identification of the advantages and barriers for implementing patient empowerment practices.***

Disease management should be a **patient-centred approach** in which care delivery is optimized:

- optimal cooperation between multiple healthcare professionals with
- right skills, from different disciplines, and different institutions
- patients actively involvement in their care process and manage the disease within their competence for an optimal result - ***patient empowerment***
- ***central role of the patient*** in chronic disease management

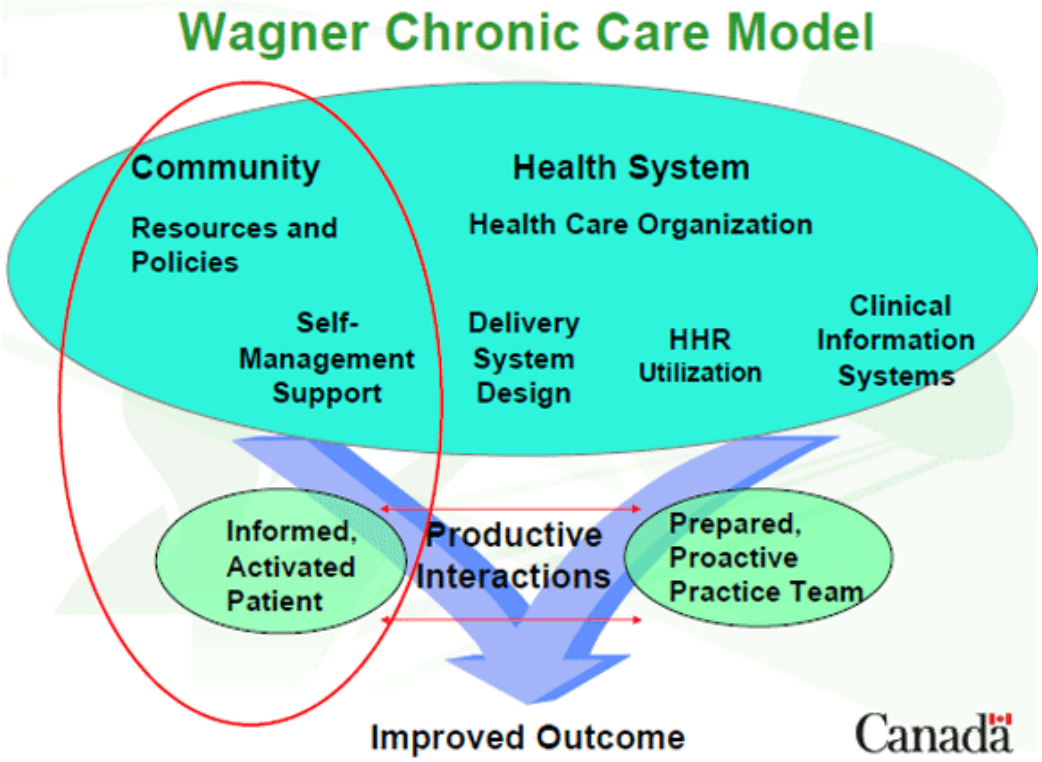
Patient empowerment integrates multiple concepts that enable a person to effectively self-manage his disease

The Chronic Care Model (CCM)

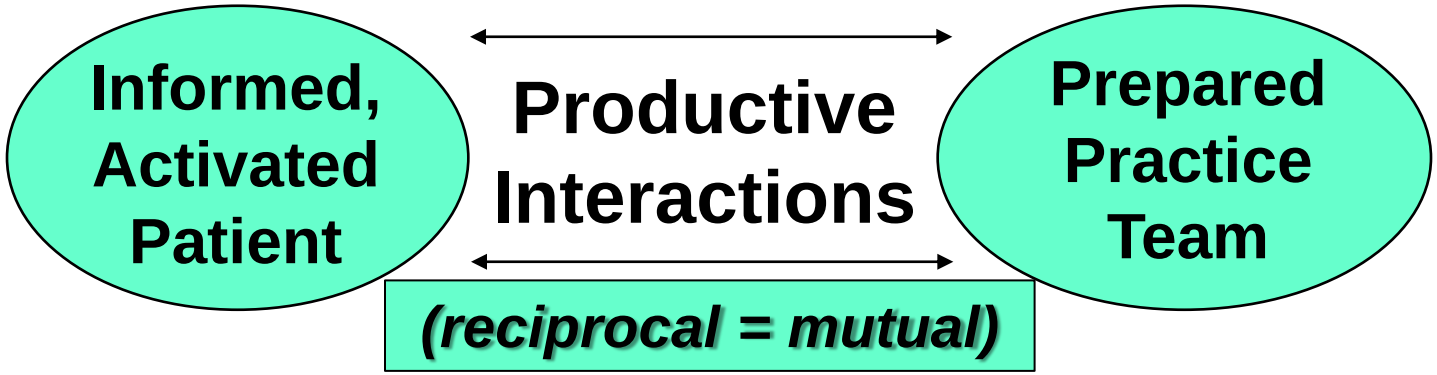
- based on the premise that **high-quality chronic care** is characterized by **productive interactions between the practice team and patients**, involving assessment, self-management support, optimization of therapy and follow-up.

- the CCM aims to provide a **comprehensive framework for the organization of healthcare to improve outcomes for people with chronic conditions** (Wagner et al. 2001).

Chronic Care Model (CCM)
(Wagner et al. 1999)



Essential Elements of Good Chronic Condition Care



What characterizes "informed, activated patients"?

They have the motivation, information, skills, and confidence necessary to effectively make decisions about their health and manage it –

- By SELF-MANAGEMENT SKILLS SUPPORT.

What characterizes "prepared" practice team?

At the time of the interaction they have the patient information, decision support, and resources necessary to deliver high-quality care.

Self-Management/Care Skills Support:

Empower and prepare patients to manage their health and health care:

1. **Emphasize the patient's central role** in managing their health. Providers should reinforce the patient's active and central role in managing their illness

2. **Use effective self-management support strategies** that include assessment, goal-setting, action planning, problem-solving, and follow-up. Evidence now strongly suggests that to achieve optimal outcomes in most chronic conditions, **we must improve the patients ability and interest in managing their own condition**.

3. **Organize resources to provide support.**

Defining self-care, self-management and self-management support

Self-care

The WHO defines self-care as "**the activities that individuals, families, and communities undertake with the intention of enhancing health, preventing disease, limiting illness, and restoring health**" *(WHO 1983).*

The Department of Health (USA 2005) uses a similar but slightly elaborated definition of self-care: "**the actions people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; maintain health and well-being after an acute illness or discharge from hospital**".

Self-care can include a broad range of activities ranging from **doing nothing in a particular situation** (*Haugh et al. 1991*), **or taking painkillers for a headache, or patient developing expertise in managing a long-term condition** (*NHS Scotland 2005).*

Defining self-care, self-management and self-management support

Self-management

- first used by Creer in the mid 1960s to denote the active participation of patients in their treatment (Koch et al. 2004).
- **the aim of self-management is to minimize the impact of chronic disease on physical health status and functioning, and to enable people to cope with the psychological effects of the illness** (Lorig and Holman 1993).
- self-management is described as a **collaborative activity between patient and healthcare practitioner** (Lorig 1993).
- at-home management tasks and strategies are undertaken with the collaboration and guidance of the individual's physician and other healthcare providers (Clark et al. 1991).
- as such, self-management is not regarded as an option but rather as **an inevitable series of activities that should be an integral part of primary care** (Glasgow et al. 2003).

Defining self-care, self-management and self-management support

Self-management support

- involves **a patient-centred collaborative approach** to care and to promote patient activation, education and empowerment (Goldstein 2004).
- **expands the role of healthcare professionals** from delivering information and traditional patient education **to include helping patients build confidence and make choices that lead to improved self-management and better outcomes** (Coleman and Newton 2005).
- is **the key feature of the Chronic Care Model**, which emphasizes the centrality of an informed, activated patient to **productive mutual/reciprocal patient–provider interactions** (Glasgow et al. 2002).
- includes **patient education, the collaborative use of a wide range of behavioural-change techniques to foster lifestyle change, the adoption of health-promoting behaviours and skill development across a range of chronic conditions** (Farrell et al. 2004).

Forms of Care (introduction)

	Informal	Hybrid forms of care	Formal
Unpaid	Family care Informal care networks	Care shared by family and formal services	Human service volunteers
Paid	Domestic employees	Care allowances, tax credits and cash payments. Use of private domestic help	Paid care workers, professionals: MDs, nurses, PTs

Family members or friends who provide support to children/adults who have a disability, mental illness, chronic condition are referred to as **unpaid carers**. Carers can be parents, partners, grandparents, sisters, brothers, friends or children.

INTERDEPENDENCE of LIVING ORGANISMS

- The picture shows a bee visiting a sunflower
- It provides an example of interdependence
- The bee is dependent on the flower for its nectar
- The flower is dependent on the bee for pollination

Interpersonal Interdependence

- **Dependence Paradigm – all about you**
- **Independence Paradigm – all about me**
- **Interdependence Paradigm – all about we**

Interdependence is when people share their skills, abilities or energies with others and in the process create a stronger, more successful reality.

Interdependence
– what it means for our M-CARE Project

"***What we do with our lives individually is not what determines whether we are a success or not; what determines whether we are a success is how we affect the lives of others***." (Albert Schweitzer)

- Interdependence is about **relationships that lead to a mutual acceptance and respect**.
- It suggests a fabric effect where **diversity comes together in a synergistic way to create an upward effect for all people**.

"***Human beings are not like amoebas, we're not things. We're much more like coral, we're interconnected. We cannot survive without each other***." (Willard Gaylin)

Aims and objectives (I)

Key objectives:

- To understand, define, develop and promote good practices in **supporting families** to plan for a future where a person with chronically illness/disabilities is providing care to their elderly carers **through the concept of "mutual caring"**

- To **redefine** the terms **"care"** and **"dependency"** into **"mutual care"** and **"interdependency"**

- **To introduce** new concepts/approaches of **"mutuality and resonance"**, **"collaborative care"**, **"mutual approach"** and **"patient/family-centred care"** as the cornerstone in facilitating education, health and social care programs

Aims and objectives (II)

- To identify, share and exchange best practices
- To create the M-CARE website to offer free resources to family carers, patients/people with disabilities, and care professionals on how to cope their common problems
- To be a learning experience that will improve our intercultural competencies, learning/training opportunities in EU member countries and organizations

Target groups

- People with special needs/disabilities/chronically conditions and their family carers
- Health care professionals: medical doctors, kineto- and physiotherapists, nurses, psychologists
- Sociologists, social assistance and care workers
- Educators and teachers
- Volunteers

MAIN ACTIVITIES
for 2 years: 2013-2015

- **5 Transnational Meetings** – hosted by each project partner
- **12 mobilities for each partner, *24 for DGASPC RO***
- **4 Workshops** – organized at the first 4 meetings
- **Final International Conference "Mutualistic approach and strategies in adult health education"** - at the last 5th meeting
- **Learners needs analyze**
- **Local activities: documentation, 4 Local Seminars**
- **Realization of printed/online educational materials "M-CARE Handbook"**
- **Dissemination: local, national, European level**

1st year RESULTS (I)

Project start date: August 2013

Tangible results:

Virtual outputs:

- **the M-CARE project website** http://www.m-care.eu/
- **the M-CARE Yahoo Group** https://groups.yahoo.com/neo/groups/mutual-care/info
- **the M-CARE Facebook page** https://www.facebook.com/M.Care.eu

Events:

- **the 1st Transnational meeting in CRAIOVA (Romania), and the 1st Transnational workshop: "Conceptual frameworks and their applications in care-process", more than 50 participants.**
- **the 2nd Transnational meeting in KRAKOW (Poland), and the 2nd workshop: "Educational challenges in social and medical care – elderly care", more than 50 participants.**

1st year RESULTS (II)

Products:

- **Start up leaflet of M-CARE project**
- **Project logo**
- **Participants Profiles/Country presentations**
- **Workshop presentations**
- **Report of the 1st meeting, photo gallery, on-line**
- **Report of the 2nd meeting, photo gallery, on-line**
- **Local seminars organized by each partner**
- **Intra-/interinstitutional dissemination - articles in newspapers, partners websites**

2nd year Timescale (I)

To DO:

- **The 3rd Project meeting/workshop "Educational challenges in social and medical care – disability care", RIGA, 19th - 24th of September 2014**
- **exchange of experiences and good practices, know-how transfer**
- **study visits to relevant places.**

- **to understand the carer-patient dynamics and the mutual exchange of care between the carer and care recipient**
- ***to understand why "Mutuality" should underlie the educational approaches on disability care issues and could redesign educational systems***
- **know how transfer, exchanging information/experiences and good practices**
- **to increase knowledge and personal skills of project learners.**

to understand why "Mutuality" should underlie the educational approaches on disability care issues and could redesign educational systems

Grundtvig Learning Partnerships
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http://nmd-pro.ro/

NMD-PRO
Neuromuscular diseases: professional parents and patients

The idea …

- **everybody has something to learn from each other: parents from health care and social professionals, specialists from parents and patients, and everyone has to learn from others.**

How ?

- **support, training and raising the educative, social, health knowledge and competencies for affected parents or NMD adult patients**

- **transferring these competencies from them to caregivers, for all become a kind of educational service providers:**

"NMDs professional parents and patients"

→ **NMDs Educational Needs Questionnaire**

We realized and used this questionnaire to establish the needs on lifelong learning training on NMDs issues for patients or their families, health/social carers, decision makers.

→**Research Paper: "Needs analysis of lifelong learning on neuromuscular diseases for Romanian participants to NMD-PRO Project"**

This survey offer different aspects concerning the needs for medical/caring education in NMDs, on Romanian target groups, and point the possible gap between the EU policy and programs and the general public awareness on neuromuscular diseases.

→**Guidebook for NMD professional parent/patient**

This educational material support NMDs affected patients/parents, health/medical practitioners and anyone seeking to develop more knowledge about these disabling disorders, about what it means multidisciplinary team management, family-centered care and parent-to-parent approach.

M-CARE
2nd year Timescale (II)

- **The 4th Project meeting/workshop "Mutualistic and collaborative approaches in care process"** – **23-25 March 2015, ROME, Italy**
- **The 5th Project meeting and Project Final International Conference "Mutualistic approaches and strategies in adult education"** – **19-22 May 2015, CRAIOVA, Romania**

- Printed/online educational materials **"M-CARE pro Handbook"** (in English and partners languages) - **June 2015**
- **"M-CARE Project Booklet"** in English and all partners' languages - **June 2015**
- **Final report** and recommendations – **July/August 2015**

Thank you for participating!

Paldies!