TEC-MED Model

Final report

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Abstract	The TEC-MED project was funded by the European union with the objective of development and pilot a socio-ethic and cross-cultural care model in 6 countries from the Mediterranean basin (Spain, Greece, Italy, Egypt, Lebanon, and Tunisia). as a results of the formative research carried out in the work package 3, the state of the art, which consists in three activities: analysis of the 20 most promising initiatives in Europe and the Mediterranean basin aimed to the social care of elderly,

	analysis of the current social care systems in thecountries participants though semiestructured interviews and swot analysis, a gap analysis through a Delphi study, and, finaly the TEC-MED model development and validation with experts in several meetings. the TEC-MED model is an integrative person cented model of care for dependent and/or at risk of exclusion elderly people. it has six dimensions (subject ofcare, social and health providers, environment and system of care, technology, financing and governance), 5 key concepts (quality, research and dissemination, ethic, gender, social inclusion, transculturality), at the three level of management (micro, meso y macro level). the operationalization of the tec-med model could be a catalyst to promote quality services based on a socio- ethical and cross-cultural model for the elderly in the Mediterranean basin

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TEC-MED first Draft model

1.INTRODUCTION

Nowadays, 200 millions of people in the world have reached or surpassed the health life expectancy (60 years), that is the 12% of the world population. These figures will increase in the following three decades, where people older than 60 years old will duplicate in number, and octogenarians will quadruplicate (World Health Organization, 2020). The higher life expectancy, become an achievement of the public health policies and of the socioeconomic development; and has also brought the existence of a higher elderly population but not with a consistent life quality, showing high rate of fragility and dependence (Brañas et al., 2018).

The age increase in the population, has also brought an increase of dependent people. The dependence can be defined as the loss of physical, psychological and functional capacity. This situation increases the complexity of the care process and the care demand (Martins et al, 2013).

In accordance to the current demographic development, over 50 million people in Europe have more than one chronic disease, and over 100 million are at risk of poverty or social exclusion. As a consequence, health care spending will increase to a staggering 20% of the country specific budget (Eurostat Statistics Explained, 2018).

The World Health Organization identified some key components of well-functioning health system, responding in a balanced way to a population’s needs and expectations by improving the health status, protecting people against the financial consequences, and providing equitable access to person-centered care. These components are: leadership and governance, health information systems, health financing, human resources for health, essential medical products and technologies, and service delivery (WHO, 2010).

Some of European Projects, regarding to dependent elderly people, wellbeing and quality of life have developed their frameworks based on these concepts, like ICARE4 (Melchiorre et al, 2018), We DO Project (European Commission, 2012), and Sustain

Project (de Bruin et al, 2018). All of them are based on the use of new technologies, governance importance and human resources improvement. Some of them as well as other initiatives based their frameworks also in the integrative care, like Selfie (Leijten et al., 2018), Integrate (Borgermans et al, 2017), Chrodis (Palmer et al, 2019), Pilares Foundation (Fundación Pilares, 2018), Aging Lab Foundation (Rodríguez & Cruz, 2016), Borough model (Turner & Murray, 2019) and Sant John of God Model (Orden Hospitalaria de San Juan de Dios, n.d.). The integrative care appears a core element in an elderly quality life improvement projects. By the other hand, other projects based its approaches on the multi-professional intervention and multidimensional assessment of elderly people, like Comunità di Sant'Egidio (Marazi et al, 2015), Lebanese Center for Palliative Care-Balsam (The Lebanese Center for Palliative Care, 2018), Open Care Centers por older people KAPI (Sourtzi ET AL 2010) and Sekem Medical Center (Sekem Medical Center, 2019).

Nevertheless, all of them consider the multidisciplinary approach to improve the dependent elderly people or in social risk in their model frameworks.

A table with an analysis of the main themes of a total of 20 most promising initiatives that were reviewed from the European Union and Mediterranean Basis in relation with the dimensions of the TEC-MED Model can be found at **annex 1.**

Additionally, Integrated and Person-Centered Care (PCC) stands as an innovative line, which requires integrated socio-health care in recognition and value of the uniqueness of each individual (Martínez, 2020).

In this sense, the countries of southern Europe, cradle to some of the oldest civilizations in the world, in addition to sharing cultural ties, are now more than ever facing these needs. The current health crisis situation has highlighted the need to work towards a model that increases the capacities and competences of care providers related to vulnerability and the elderly, to incorporate them into Social and Health Policies.

The TECMED research project of the ENI CBC 2014-2020 call addresses these challenges, developing a model of cross-cultural, ethical and social care for the dependent population in the Mediterranean basin. With an approach based on justice, privacy, confidentiality, gender, universal accessibility, active community participation

and the values of the welfare state and governance.

2. SCOPE OF THIS DOCUMENT

This document answers to the objectives of WP3 to Create the TEC-MED Model. For achieve this first draft, formative research was carried out with the following objectives:

- To know which are the most promising social assistance initiatives for older people who depend on the risk of social exclusion in the countries of the European and Mediterranean basin through an extensive literature review.
- To recognize social care practices in each of the countries involved in the Project as well as their strengths, weaknesses, opportunities and threads through semi-structured interviews and SWOT analysis in the participant countries participants in the TEC-MED project.
- To analyze the Gap in the participant countries in the TEC-MED project through a Delphi panel.

With this all formative researches together with a meeting that was carried out in the 29th of June of 2020 (annex 2) with international experts from the Mediterranean Basis was refined the Definition of the TEC-MED Intervention Framework to propose the TECMED Model.

An Intervention Framework is the pillars that guide the construction of a model. A model is the way of understanding or interpreting these pillars or conceptual bases. Therefore, in this document, the pillars are first presented (Theoretical framework or metaparadigm) and then are interpreted with the TECMED vision (TECMED Model) to respond to the model's mission:

- **Vision:** Worthy care for the elderly.
- **Mission:** Serve as a catalyst to promote quality services based on a socio- ethical and cross-cultural model for the elderly in the Mediterranean basin.

3. THEORETICAL FRAMEWORK OR METAPARADIGM

The term of paradigm provides the basic parameters and framework for organizing a discipline knowledge. The metaparadigm of a discipline is distinguished from a paradigm because of it is global, philosophically neutral and fairly stable (Peterson & Bredow, 2009). The fundamental notion of that a metaparadigm presents a distinctive domain with a unique perspective. The core concepts of the metaparadigm, that should be well defined before designed and structuring a model are: health,subject, rol, and context (Fawcett, 2013). Subsequently, the less abstract level, and morespecific and explicit are the conceptual models (Benner et al., 2003).

3.1. Theoretical Framework and levels FRAMEWORK TECMED

The dimensions of the theoretical framework of the model are: 1. Subject of care; 2. Health and social care providers; 3. Care environment and Service delivery; 4. Governance; 5. Financing and 6. Technology.

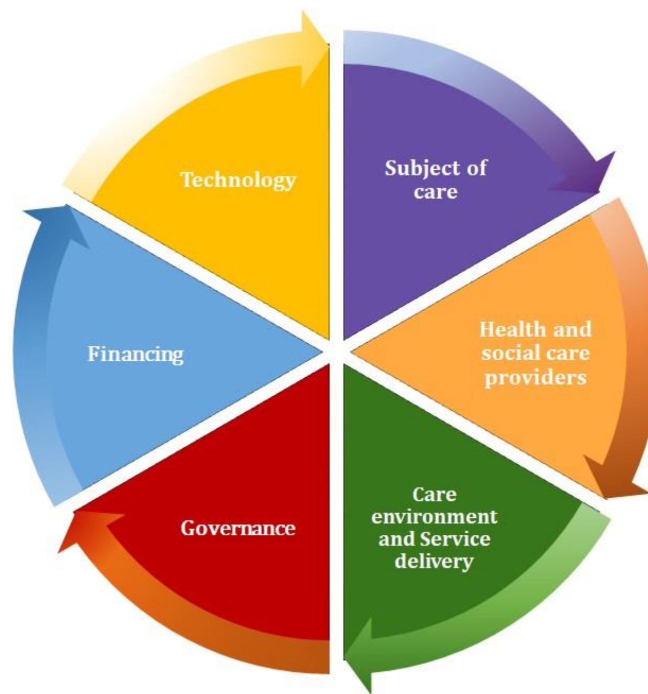

Fig. 1. Theoretical Framework TECMED Model

For each of the dimensions, three levels of action are defined: macro, meso and micro (UNESCO, 2012; Barrientos-Trigo et al. 2018):

- Macro management: Macro refers to the government, political or legislative level, leadership position in public administration which provides social-care services (may include policy makers and other stakeholders).
- Meso-management: refers to the organizational level such as local government or care management in the hospital, nursing home, etc.
- Micro management: refers at the individual level. Person, social professional attending dependent, health and social care provider, family caregiver.

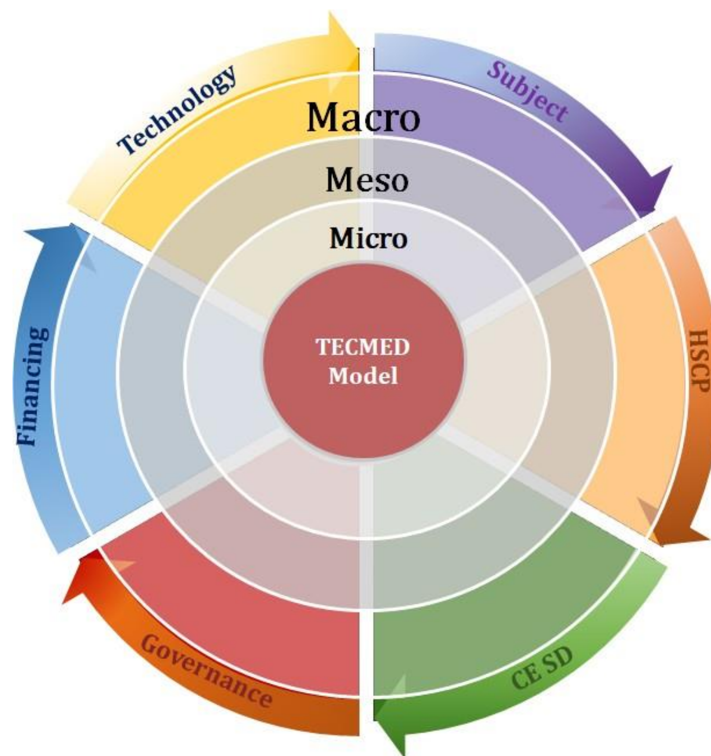

Fig.2. Theoretical Framework Level of Dimensions (macro, meso, micro)

The dimensions of the framework are described below:

I. Subject of care:

- Person is the subject of attendance. Person should be placed in the center of the system, and his needs should be the starting point of the care process. Moreover, person is not (only) a patient or client of health or social care; is a person living a life connected with other people in and social environment. Nevertheless, the family, societal resources and networks in the community may be considered as the object of the attendance and caring.
- Well-being perception and daily functioning, autonomy, and participation in society are highly relevant goals from a patient perspective. A holistic understanding of their individual health and well-being, capabilities, self-management abilities, needs, preferences, and their direct socio-economic environment is mandatory. The health of an individual not only includes the whole spectrum of physical, mental, and social well-being, but also the ability to

adapt and self-manage. The capacity for resilience and the ability to cope and restore a balance are also part of this broader definition of health.

- It is extremely the importance of addressing the Social determinants of health, in particular for health inequities. Since 2018, a renewed WHO organization-wide commitment to acting on determinants of health, and broader social determinants and health equity. These determinants are including in WHO's 13th General Programme of Work 2019-2023. The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. The 2030 Agenda for Sustainable Development underlines the importance of addressing social determinants. At this respect, social inclusion, and social protection of vulnerable people must be addressed.
- Levels:
  - Macro: Community
  - Meso: Family; Caregiver (formal/family)
  - Micro: Individual; Caregiver (formal/family)

II. Health and social care providers:

- Health and social providers are central for the person achieving the better state of health and well-being. They should focus the attention on the person with an integrative, multi and interprofessional perspective. For a well and efficient performance focus on the quality and the outcomes of the client it is necessary there should be available the sufficient resources (number, diversity, competencies, well-payment, balance and stability over time of workloads). Professional should be training focus in capacity building from a interprofessional perspective with equity in the treatment of all workers, they should participate in decision-making processes decisions, care guideline must be developed to guarantee the quality of care, should be have a favorable vision of their social

contribution.

- Levels:
  - Macro: Workforce policy and planning, capacity building and training planning.
  - Meso: Social care team's management, staff management
  - Micro: Multi and interdisciplinary teams including health and social professional, formal and family caregivers.

III. Care environment and Service delivery:

- **Care environment:** It is the context where the care is delivery, which refers not only to the physical environment, that includes, accessibility, accommodation (including services, cleaning, no architectural barriers), if not also to the conditions in which the care is development, including the social environment, psychological and human aspects (humanization), hospitality, warm, affection, response to the person-needs and, among others issues.

  The care can be developed in their own homes, daily facilities, home cares, and other community resources, including family needs, should be considered as the intervention context. A holistic understanding cannot be seen separately from the direct socio-economic environment of an individual: environment (social networks, financial situation, housing, the physical surroundings, the availability of community services, means of transport).
- **Service delivery:** According WHO (2010) health and social systems are only as effective as the services they provide. They shape the conditions that facilitate (or hinder) the provision of patient-centered integrated care in a region or country, as well as broader society.

  The capacity of giving quality and effective services are related as having a center of the system that serves as enter point to the subject of care, this could the primary care level, having a harmonious coordination at horizontal and vertical levels (at the same and at different institutions and services). That allows to give an integrated range of health and social interventions that respond to the full range of conditions of the target populations, rules and standard practices to

ensure accessibility and quality of care related to sustainability, safety, effectiveness, continuity, and people-centeredness, having mechanisms to involve the user in the design and planning of care, including planning and decision shared.

- Levels:
  - Macro: Policy and regulation of care environment and integrative care cross organization and sectors in the Social and Care System, availability and accessibility (universal), market regulation (from an inclusive perspective), involving the community (solidarity and volunteers), bottom-up development.
  - Meso: Management of the care environment focuses on the physical, psychological and human factors from a housing perspective, local and regional networks and integrative organization, structures and processes, continuous quality improvement system, evidence based standards.
  - Micro: Adaptation of the care environment to the person's needs; proactive, individualized, shared decision and planning, family caregiver involvement, continuity.

IV. Governance:

- Governance is the process by which social care organizations guarantee good service delivery and foment positive outcomes for people who use services. It consists in a wide range of steering and rule-making related function carried out by governmental/decisional makers. The governance is oriented to develop implementation and change strategies tailored to different care settings and contexts in Europe and Mediterranean area.

  From the macro level, good governance should be oriented to be independent from political orientation, guaranteed by fair financing and with the development of legislation that universally protects with equity, throughout the national territory, all citizens regardless of their resource. An optimal governance model should count on a strong coordination network, of all actor's levels and resources. From the meso level, policy and action plans and political commitment are aimed

at protecting the ethos of autonomous practice, integrated care programs, community-based practice, high levels of client and staff satisfaction, financial sustainability, customer empowerment and comprehensive care with a primary focus on clients with complex health and social issues care needs.

The health service providers fallow a performance-based management and creating individualized care planning coordination tailored to complexity, counting on a less bureaucracy and offering all support functions. In this sense, the citizen is a primary and active actor in the choice of care policies sharing decision-making.

- Levels:
  - Macro: the State (government organizations and agencies at central and sub-national level)
  - Meso: the health service providers (different public and private for and not for profit clinical, para-medical and non-clinical health services providers; professional associations; networks of care and of services)
  - Micro: the citizen (population representatives, patients' associations, CSOs/NGOs, citizen's associations protecting the poor, etc.) who become service users when they interact with health service providers.

V. Financing

- Financing is the economic support system of any model. The possibilities are: public, private, mixed or nonprofit. This term includes the financial and accounting system, financial sustainability, financial performance and other question relation with financial matters. This term includes the funding priorities at the political level and the government level.
- Levels:
  - Macro: Government and political level
  - Meso: Financial management of entities
  - Micro: Financial support to the target population and funded services.

VI. Technology

- A support system to complete the model. Technology is referred to online support to record the information and to store the information. Roadmap, tools, lessons learned reports, scientific evidence and good practices can be stored in the technology platform.
- Technology can be used to train the target population, or the healthcare providers. Also, it is possible the use of monitoring the working times. Using artificial intelligence is possible to develop a roadmap and facilitate the decision-making process. This term includes telemedicine, electronic health records and other health and social platforms.
- Technology must be developed under the values of user-friendly, availability, accessibility, etc.
- Levels:
  - Macro: National support policies to improve technology development and innovation. Guaranteeing the equitable access, availability and freely available of the technology services.
  - Meso: Use of technology to coordinate the services. The coordination is possible at a local level by the City Council's health and social services or by private or nonprofit entities.
  - Micro: Use of technology to improve the well-being of the target population, e.g. telemedicine, telemonitoring. Technology support to family caregivers. Technology support to healthcare providers (training, recording, follow-up).

4. TEC-MED MODEL

A model is a symbolic representation of reality, specifically, of a phenomenon; an abstract system of interrelated concepts (Raile, 2017). Its development is needed since it becomes a conceptual context that facilitates the understanding of a complex reality (Chacín, 2008).

On the one hand, it is also needed to identify the representative core elements of the phenomenon, as well as to delve into the practical application of the theoretical relations between them (Fawcett, 2013). It allows generating new knowledge, in a grounded and reliable way, that could guide the creation of specific theories. (González & Valderrama, 2001).

On the other hand, the implantation of a conceptual framework or model guides the actions regarding the study phenomenon unequivocally, in addition to providing a common language (Chacín, 2008).

4.1. Model Basis

The model basis is a **Person-centred integrated care.**

Integrated care is defined as the structured efforts to provide coordinated, pro-active, person-centered, multidisciplinary care by two or more communicating and collaborating care providers that may work at the same or different organizations, either within the healthcare or across the health, social, or community care sector (including informal care).

A basis of **person-centred** integrated care with is a holistic understanding of their individual health and well-being, capabilities, self-management abilities, needs, preferences, and their direct socio-economic environment.

The health of an individual not only includes the whole spectrum of physical, mental, and social well-being, but also the ability to adapt and self-manage. The capacity for resilience and the ability to cope and restore a balance are also part of this broader definition of health.

It represents a comprehensive care of the health, social, spiritual and family needs of the person, and its aims are:

- Provide a benefit that simultaneously covers the social and health needs of elderly dependent person and/or at risk of exclusion, planned in the medium and long term.
- Provide accessibility, in an appropriate way to the clinical and social situation, considering the continuity of care. This is achieved by establishing the needed

measures for this purpose with the rest of the hospital's primary care and social services.

Worthy care for older people provides **decent and positive aging process** (PDE), which applies the logic on management procedures to the intervention. The principles and criteria constitute the ethical and cross-cultural framework, becoming the basis of the model, and are based on universal values that promote the dignity of the elderly, active aging and long-term care. Hence, the interrelation between theory (concept) and practice in intervention (praxis) is the key of the model development. Is also important to remark the attributes of the model, as well as its progressivity and change possibility, depending on these interrelationships (Rodríguez-González, 2016).

4.2. Key elements

The model is made up of a set of key elements that make it distinctive and at the same time have a transversal influence on its own conceptualization (Figure 3) They are: quality, research and dissemination; gender perspective, ethics, social inclusion, transcultural.

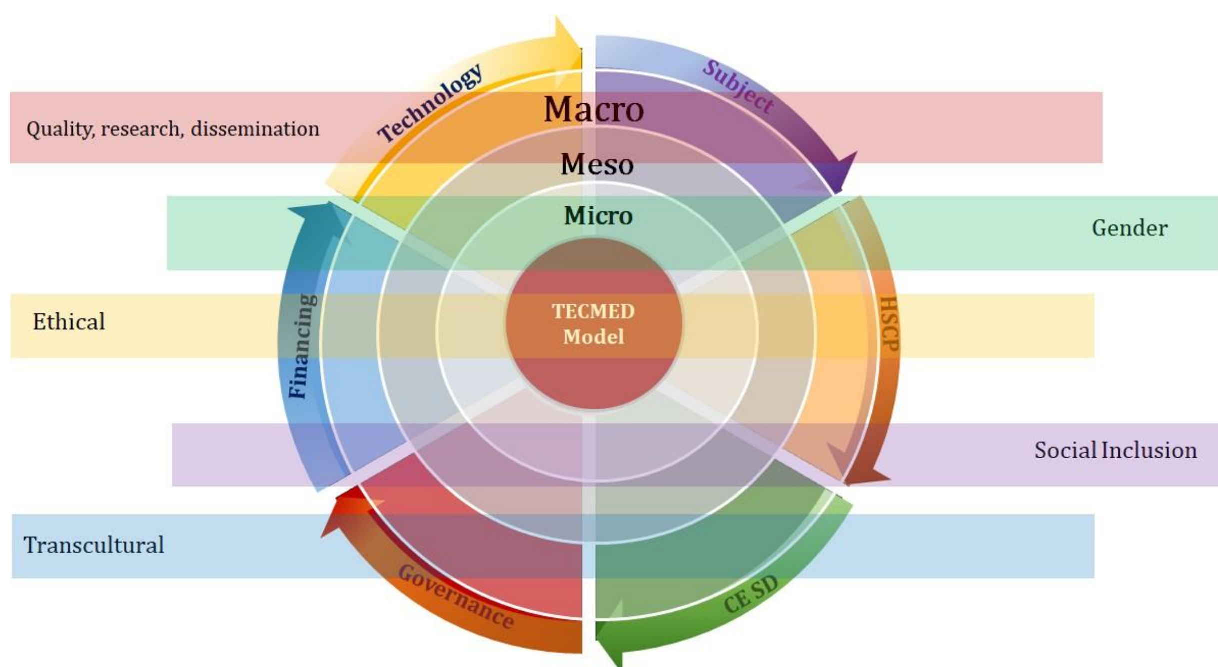

Fig.3. Theoretical Framework Level (macro, meso, micro) and transversal concepts of the model

• **Quality, research, dissemination**

Quality is a basic tool for a natural property of any good or service that allows it to be compared with any other good or service of its kind and satisfy stated or implied needs. A model of care for dependent elderly people and / or in risk of social exclusion should be linked to aspects such as respectful human rights and dignity, person-centered, preventive and rehabilitative, available, accessible, affordable, comprehensive, taking into account the transparency, bottom-up perspective. In this way it maximizes the quality of service for the elderly, the quality of professional care protecting the caregivers, and of course the quality of life of older people (Munthe et al., 2012).

Research-supported care aims to create new knowledge and / or the use of existing knowledge in a new and creative way so as to generate new concepts, methodologies and understandings, all of which contribute to increased quality and performance a social care based on the best evidence. According to European Commission (n.d.), dissemination means sharing research results and practices with potential users - peers in the research field, industry, other commercial players and policymakers, including the transfer. By sharing your research results with the rest of the scientific community, you are contributing to the progress of science in general.

• **Gender**

Gender refers to the roles, behaviors, activities, attributes and opportunities that any society considers appropriate for girls and boys, and women and men. Gender interacts with, but is different from, the binary categories of biological sex. Gender intersects with other factors that drive inequalities, discrimination and marginalization, such as ethnicity, socioeconomic status, disability, age, geographic location and sexual orientation, among others (WHO, Health topics, n.d).

Promoting equal economic independence for women and men, closing the gender pay gap, advancing gender balance in decision making, ending gender based violence and promoting gender equality beyond the EU.

If gender is taken into account, studies research how they affect the gender

inequalities of the patriarchal system and how dependency and gender interact in older couples. The possibility of changes or flexibility of gender roles and mandates is also studied.

Furthermore, in relation to this topic, the focus is placed on care relationships in old age, highlighting the role and contribution of paid care work and not paid.

- **Ethical**

Social care must meet a set of standards of conduct that guide decisions and actions based on duties derived from core values (Consejería de Igualdad, Políticas Sociales y Conciliación de la Junta de Andalucía, 2019).

In this sense, it must be taken into account the autonomy as a right of a person to determine his or her own destiny; the beneficence as a way of doing good (not only just the client but also the family and the social and healthcare professionals); the justice as a way of seeking the sharing of benefits and burdens based on fairness and equality. When any of these ethical principles are overlooked, a person may be at risk for neglect or abuse (American Society of Aging, n.d).

Based on Rodríguez-González (2016) the bioethics includes the following dimensions: justice (e.g. protocol for the use of contentions mechanics that do not compromise people rights), privacy and confidentiality (e.g. Control of confidential and own documentation of users), autonomy and empowerment (e.g. generate decision-making, based on respect for the self-determination of the user).

- **Social inclusion**

The capacity of a society to ensure the welfare of all its members, minimizing disparities and avoiding polarization (European Committee for Social Cohesion, 2004).

Social inclusion is about having access to opportunities, options and choices in life and having the resources and appropriate support as well as the personal capacity, self-confidence and individual resilience to make the most of them.

Older people should be treated fairly and with dignity, regardless of disability

or other status, and should be valued independently of their economic contribution (United Nations, 2002). Enhancing elderly people's social inclusion could be highly beneficial in terms of mental and physical health. For example, elderly people can continue participating longer in employment as a way of having higher incomes and being more active. (Yur'yev et al., 2010).

- **Transcultural**

Relating to or involving more than one culture; cross-cultural. Encompassing, or combining elements of more than one culture.

The transculturally is defined as the phenomena that result when groups of people, who have different cultures, make continuous first-hand contact, with consequent changes in the patterns of the original culture of one of the groups or both (Marrero, 2013). Transculturally does not necessarily imply a conflict, but consists of a phenomenon of cultural enrichment.

Culture, constituted by the values, beliefs, ways of living and traditions that are transmitted from generation to generation, is understood as an element that configures behaviors and ways of being and acting (Murphy, 2006). There is not only universal social and health care (aspects common to all cultures), but also diversities

(particular and specific care of each culture) that must be taken into account (Leininger, 2002). Thus, people from different cultures can inform and guide professionals to receive the type of care they need. Social and health workers should discover and acquire knowledge about the patient's world, and making use of it, make appropriate decisions to provide care consistent with culturally marked (Castrillón, 2015).

Usefulness of the Patient-Centered Culturally Sensitive Health Care Model for explaining the linkage between the provision of patient-centered, culturally sensitive health care, and the health behaviors and outcomes of patients who experience such care (Tucker et al., 2011). The delivery of care that is culturally appropriate prevents unnecessary conflicts between clients and caregivers from varied cultural backgrounds.

4.3. Conceptualization

A conceptualization of the metaparadigm of the TEC MEC Model is the basis of its creation:

Central role: The central role in the TECMED framework is given to older person's dependent or at risk of social exclusion

The core: holistic understanding and the dignity of the person

I. Subject of care

Model TECMED the subject of care is the Ederly of 65 dependence and/or risk of social exclusion.

Elderly: At the biological level, ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time. This leads to a gradual decrease in physical and mental capacity, a growing risk of disease, and ultimately, death. But these changes are neither linear nor consistent, and they are only loosely associated with a person's age in years. While some 70 year-olds enjoy extremely good health and functioning, other 70 year-olds are frail and require significant help from others.

Beyond biological changes, ageing is also associated with other life transitions such as retirement, relocation to more appropriate housing, and the death of friends and partners. In developing a public-health response to ageing, it is important not just to consider approaches that ameliorate the losses associated with older age, but also those that may reinforce recovery, adaptation and psychosocial growth (WHO, 2020b).

Dependency is defined as the permanent status, derived from age, illness or disability, and linked to the lack or loss of physical, mental, intellectual or sensory autonomy. It requires the care of other people to carry out basic activities of daily life or other supports for their personal autonomy (Boletín Oficial del Estado, 2006).

By the other hand, **social exclusion** can be understood as a number of social mechanisms leading to threats to the integrity and cohesion of the collectivity and challenges to the common identity of their members (Vykopalová,2016). According he European Unions, the factor related to social exclusion in Europe are:

- Changing family structures, urbanization and demographic and technological development
- Societal factors: different welfare systems, the political climate and culture.
- Community factors: Opportunities for neighborhood contacts, access to transport and services, activities and the living environment. Empowerment.
- Individual factors: health, personality, personal resilience and access to technology-& psychological empowerment

While the drivers are:

- Drivers: ethnicity (migrants), sexuality, poor health or disability, gender (older women, affected by widowhood, care provision and less financial resource), age (more than 80), income (deprived areas or regions with declining populations, unemployment) education (low skills) and life events such as the death of a partner, moving homes, retirement or living alone.

II. Health and social care providers

Multi and interdisciplinary teams including health and social professional, formal and family care included shared accountability and responsibility. It must be promoted the clarity about each other's expertise, roles and tasks, from a transdisciplinary horizontal perspective (equity).

Workforce policy and planning focused in capacity building and training must be considered, including the preparation for social and health interdisciplinary teams and staff management. The health and social care providers must be involved in the designing and evaluation of this policies.

The health and social workforce performance should be defined by: coverage, productivity, technical quality, service quality. The performance of the Social and Health Care should respond to the principles of: equity; effectiveness; efficiency; financial protection. These principles guide the creation of the Code of Professional Practice for Social Care. Financing and incentive for investing in an adequate workforce it is needed to assure the enough human resources.

To deal with these objectives, it's important to create an efficacy Leadership and Management Setting in Health and Social Care establishing inter-professional programmers for people able to improve the quality of health or social services and acquire the necessary skills. In our model the caregiver is one of the fundamental actors to be able to offer a digital care service, in this sense it is proposed to create a support system. Focus in construction of a solid network, exchange of knowledge and internal communications must be considered. It must be enhanced the specialization in social care as well in the basis of the Model.

III. Care environment and service delivery

The Law Commission in the UK has defined social care as 'the care and support provided for those who need extra support; it includes traditional services such as care homes, day centers, equipment and home care and can extend to non-traditional services such as gym membership, art therapy, personal assistants, emotional support, and classes or courses'. There have been subsequent discussions regarding where the boundary between health care and social care is and how broad/ambitious the scope of social care should be (Pike & Mongan, 2014). In the TEC-MED model we advocate for an integrated social and health care. The ideal is a perfect coordinated care that responds to all the patient needs and preferences, from a holistic bio-psico-social perspective, including the person in the care process with a person-centered vision.

In the Mediterranean basis the preference of the people usually is staying at home as long as they can. To achieve this is necessary that the home environment is of quality and adapted to the needs of a person that could have difficulties with carrying out some daily life activities, either basic or instrumental. So it is important

to create a supportive environment with enough resources, material and human, although the objective must be to maintain the people's autonomy as long as possible and promote positive active healthy ageing, by promoting self-management/personal skills and capabilities as resilience. The vision of the service must be focused on proactive health promotion and prevention, including the fight with the abuse, or neglect.

When it is not possible to stay at home there should be housing alternatives focused on the person's needs and preferences, which should be designed with the participation of the elderly people. Architecture in nursing homes should be designed from a "home perspective", but the preference must be to maintain the individual at home or in housing alternatives. Moreover, should be services of medium-long stay for those frailty and multimorbidity people that, after staying in a hospital for an exacerbation of a health problem are not able yet to go back to home.

In this process which participates in different services and institutions they must be perfectly coordinated, and involve strengthening the community and capacity action involving health and social services, formal and informal social care networks, meetings, leisure and social communication, transport, financing, from a double perspective in the coordination at horizontal and vertical levels assuring the continuity of care.

For optimal coordination there should be a single point entry should be a single point of entry, preferably at the primary care level where it must be named a social--health care coordinator of multi and inter multi professional teams.

The coordination and integration must be considered from an organizational, structural and processual point of view. It is important reaching agreements, designing care standards, development of common measures and outcomes, and outcomes procedures and tools, involving the population in designing services and procedures from a bottom-up perspective and evidence-based. An information system that includes social and health history should be used.

The focus must be the subject of care (person and family), including assessment of individual needs, stratification of care, individualized evidence-based plans with his/her involvement and participation in the care process including decision support

and shared, shared planning of care, empowerment, including multiple solutions, long-term care and palliative care.

Periodical evaluation must be developed with measurement and analysis and results based in performance and outcomes indicators, as well as financial performance indicators. Principles such as safety, efficiency, availability, accessibility, continuity, affordability, transparency and sustainability must be taken into account. Feedback mechanisms must be included with the staff and the population from a bottom-up perspective.

IV. Governance

Users and family members must participate in the design of policies to ensure that they truly meet the real needs of dependent elderly people and / or at risk of social exclusion. Leaders representing these groups should be on the governance teams and taking part raising awareness of social determinants and gender. Policies must have continuity over time, beyond political changes at the local or national level. The management and availability of services and resources should be adequateto the needs of the population according to territoriality. It is recommended that policies based on active and positive aging (WHO, 2002) and long-term care predominate. Governance should include planning and management of needs assessment studies and quality assessment systems for policies and the care provided.

V. Financing

To promote financing public, universal and transparency. Transparent entrepreneurship concentrates on innovation, leadership responsibilities for performance achievement and joint financial agreements to guarantee the covering and integrated care. Bet on the inclusion of a social and solidarity economy (Askunze, 2013), as an integrating concept of different perspectives of the alternative economy, such as the approach to sustainable human development, the feminist economy and the ecological economy, in order to put people and their living conditions at the center of the analysis and linking jobs with socially necessary production, with the

satisfaction of basic needs, betting on "another fairer economy". Some initiatives of the implementation are care cooperatives, social immersion companies, social currencies, time banks, barter markets, etc.

VI. Technology

Digital social interventions should be accessible at a minimum via mobile devices. Technology platform to support the population care, the training of the health and social care providers, the recording of the information, the alert notifications for users and professionals, the communication and coordination between public and private agents or actors, and for evaluating the quality of the care provided, and the policies developed and implemented (WHO, 2019).

Use of artificial intelligence and robotics to help older people manage and create a better and safer quality of life, allowing the management of activities in their environment and data management. Home Automation and Smart Home: advanced technological systems that monitor basic activities of daily life of the elderly, to cover the growing gap between the deterioration of an individual's abilities and the domestic and social demands as age advances (video surveillance systems, bracelets, smart speakers, etc.).

Technological support for monitoring and sustainable assistance (sensors and devices that allow the gas to be closed, lights to be turned on or off, or air conditioning to be managed).

4.4. Operationalization

For the operationalization of the TECMED Model, they were conducted two Steering Committee with the participation of all the PPs, the task was developed, revised and refining in several times. In this process, also collaborated the researchers of the TECMED model in Spain. In the following pages is shown the operationalization of the six dimensions of the TEC-MED model, taking into account the three level of management and the five key cross-sectional elements. The tables represent all the common views and perspectives of all countries working on the TECMED Project, in an overall effort to create a Transcultural-social-ethical-care

model for dependent population in the Mediterranean Sea basin.

I. Subject of care

Subject of Care should be placed in the center of the system, and his needs should be the starting point of the care process.

Moreover, the subject of care is not (only) the person, a patient or client of health or social care; the person living a life connected with other people in a social environment. Therefore, the family, societal resources and networks in the community may be considered as the object of the attendance and caring.

The following aspects should be considered in relation to the subject of care:

- Well-being perception and daily functioning, autonomy, and participation in society are highly relevant goals.
- A holistic understanding of health and well-being, capabilities, self-management abilities, needs, preferences, and their direct socio-economic environment is mandatory. The health of an individual not only includes the whole spectrum of physical, mental, and social well-being, but also the ability to adapt and self-manage. The capacity for resilience and the ability to cope and restore a balance are also part of this broader definition of health.
- It is very relevant the importance of addressing the Social determinants of health, in particular for health inequities. At this respect, social inclusion, and social protection of vulnerable people must be addressed. In this sense, to approach the well-being of the person in its complexity, the approach of assets for health is chosen from the beginning of social inclusion, including the population with territory inequities, especially the urban spaces in whose population there are structural situations of serious poverty and social marginalization.

Definition of the levels of managements

For the TEC-MED we considered three levels in relation with the persons as subjects of care:

- **the Individual**: describe the state of wellbeing of the individual human being as a unitary being as center or socio-health care.
- **the Family:** describe the state of wellbeing of the family as a whole or of an individual as a family member as center or socio-health care. Family is considered as a system of which health is more than the sum of their parts and is considered as center of care, from a bio-psycho-social perspective, focus in its needs rights and considering its dignity and preferences. More specifically, two or more people who maintain continuous relationships, who perceive reciprocal obligations, a sense of common meaning and share certain obligations towards others: in relation to consanguinity or by choice" (North American Nursing Diagnosis Association, 2020)
- **the Community:** describe the state of wellbeing of a community or population as center or socio-health care.

In this sense, the individual, family and community should be our subject of care, trying to answer with our model to these questions "what needs does our community have? Our families? Our individuals?"

The operationalization of the dimension is in the table 1

Table 1. Operationalization of the Subject of Care

Community	Family	Individual
Promoting health in the community as central to sustainable human and economic development (health in all the policies) Civic participation and Public consultation about needs of the elderly (employability, lifelong learning, senior volunteering, health and wellness, social inclusion; aged care services; housing; transport, research on elderly; public spaces) Community orientation to preventing an active and healthy aging and a positive vision of the elderly; healthy living habits	Promoting of family health: adequate family communication, climate, coping, resilience, functioning (create social and physical environments that promote good health for all)	Awareness an active social subject and deserving of respect, support and care from a real active aging model, which considers people in all their complexity and with a focus on well-being (physical, cognitive and emotional, socio-relational) and quality of life, as well as the promotion of activity and autonomy. Promoting empowerment capabilities, self-management

Community develop health assets mapping and promote them, including community resilience, social support, capacity building Community focus in educational development of the elderly: social accompaniment and socio-educational intervention, cultural offer, including the learning of new skills and digital competence; Physical Environment: Safer, barrier-free buildings and streets; better access to local businesses/facilities; more green spaces; nutrition security, safe, active and accessible transportation, etc.) Promoting networking and information exchange with the objective of creating a solid net of solidarity and support including inter and intra-generational solidarity and social altruism (exchange of goods, sharing of knowledge, time banks; Program offering social, recreational, and health-related servicesin congregate setting; support groups; community centers for all ages; intergenerational practice in schools and other educational institution, local government instrumentalities, sports clubs, churches, voluntary and community groups, and ethnic and cultural development groups; programs in which adults serve children and/or young people (such as tutors, mentors, preceptors and friends, caregivers); Promotion of local care ecosystems, including both the public sector and community-based initiatives, such as a care cooperative; cohousing initiatives	Promote gender co-responsibility in the field of care Family involvement in the process and decision-making Formation to family self-care Physical environment: Safer and barrier-free home; nutrition security Considering the gender and social determinants of health in the process of care of families, for example, caregiver profile (woman, non-employed…) Social inclusion of families with low resources is promoted Research and innovation is development focus in social and health needs of families Free access to activities as companions of elderly people Support groups for caregivers of people in situations of dependency.	abilities, needs, preferences. For instance, the capacity for resilience and the ability to cope and restore a balance from a preventive and rehabilitative vision Emphasis on the contribution of the older person based on life history and in our society through interactions, Individuals have to be considered under the professional codes of ethical issues by all disciplinaries involved. In this way, transcultural perspective and gender equality must be guaranteed. Raise awareness and incorporate ethical, cultural, spiritual aspects, empathy, compassion values, humanization, right to information, protection of autonomy, privacy and advance directives Promote the preferences of the person in relation to the residence alternatives, focus with a home accompaniment Focus in attention and social inclusion of more vulnerable individuals (women, older than 80, without home, living alone, migrants, ethnic diversity…) Special attention to the fragile population and promotion of

Community promotes the respect to the human and community rights of the elderly and promote inter-national harmony, including the fight with the abuse of negligence Research and innovation about the implication of the community to the positive promotion of the elderly and from the perspective of gender and social determinants Socialization and democratization of care; social dissemination of knowledge generated by self-organized social groups, and community network	Family-centered approaches with active learning strategies, transitional care, and follow-up Provide programming available and accessible to all family types based on culture, geography, and structure	palliative and end-of-life care at home Participation of the elderly in the care process Research and innovation focus in needs and preferences of elderly and vulnerability

II. Health and social care providers

Health and social providers are central for the person achieving the better state of health and well-being. They should focus the attention on the person with an integrative, multi and inter-professional perspective. For a well and efficient performance focus on the quality and the outcomes of the client it is necessary there should be available the sufficient resources (number, diversity, competencies, well-payment, balance and stability over time of workloads). Professional should be training focus in capacity building from an inter-professional perspective with equity in the treatment of all workers, they should participate in decision-making processes, care guideline must be developed to guarantee the quality of care, should be have a favorable vision of their social contribution.

Multi and interdisciplinary teams including health and social professional, formal and family care, NGO should include shared accountability and responsibility. It must be promoted the clarity about each other's expertise, roles and tasks, from a transdisciplinary horizontal perspective (equity). Workforce policy and planning focused in capacity building and training must be considered, including the preparation for social and health interdisciplinary teams and staff management. The health and social care providers must be involved in the designing and evaluation of these policies.

The health and social workforce performance should be defined by: coverage, productivity, technical quality, service quality. The performance of the Social andHealth Care should respond to the principles of: equity; effectiveness; efficiency; financial protection. These principles guide the creation of the Code of Professional Practice for Social Care. Financing and incentive for investing in an adequate workforceit is needed to assure the enough human resources.

To deal with these objectives, it's important to create an efficacy Leadership and Management Setting in Health and Social Care establishing inter-professional programmes for people able to improve the quality of health or social services and acquire the necessary skills. In our model the caregiver is one of the fundamental actors, in this sense it is proposed to create a support system. Focus in construction of a solid network, exchange of knowledge and internal communications must be considered. It must be enhanced the specialization in social care as well in the basis of the Model.

Having clarified the terms "Health care" and "Social care" providers, it is essential according to the TECMED Project to evolve them into three fundamental levels: Macro, Meso and Micro intervention. Specifically,

- **Macro:** Workforce policy and planning, capacity building and training
- **Meso:** Social Care team's management, staff management
- **Micro**: Multi and interdisciplinary teams including health and social professional, formal and family caregivers

The operationalization of the dimension is in the table 2

Table 2. Operationalization of Health and Social Providers

Workforce policy and planning, capacity building and training	Social Care team's management, staff management	Multi and interdisciplinary teams including health and social professional, formal and family caregivers
To align investment in **(H&SP)** with the current and future needs of the population and of social care systems through effective workforce policy planning To improve prioritization and planning of investment	Strength S&HP from a broad, transdiciplinar and horizontal perspective; including formal and formal providers, volunteers, caregivers, etc. Adequate training programs for staff and caregivers, focus in the social care, the basis of the	Multi and interdisciplinary teams including health and social professional, volunteers, formal and family caregivers with a focus on case management and continuity of care for socio-health care, prioritising the

in the development of a sustainable H&SP workforce towards universal health coverage with sufficient resources (coverage, productivity, diversity, competencies). To Promote favorable labor (specializations, increased training; promoting equity, Social recognition for professionals) and economic (well-payment, stability, appropriate work balance, financial protection) conditions for workers in the sector. That should lead to a Code of Professional Practice for Social Care To Promote emerging professionals in the sector: physical therapists, occupational therapists, nurses, health educators, without falling into the medicalization of social structures; To transform professional, technical and vocational education and training oriented to optimize the performance, quality and impact of H&SP Taking account gender and social determinants of health promoting the inclusion and the equality for the workforce independently of their personal and social characteristics. To promote the evidence based, strengthen data and applications that support analytical approaches to H&SP policy and planning, including a better understanding of the workforce (characteristics, size and distribution, competences, technical quality, effectiveness, efficiency) To strengthened human resources information systems and research to guide policy decisions; Multistakeholder and intersectoral policy dialogue	TECMED model, and the main cross-sectional themes: quality, research and innovation, gender, social inclusion, transcultural, and ethic; promoting capacity building. To promote adequately trained staff through University curricula and CPD Program promoting the specialization in social care Training in effective and interprofessional (transprofessional) work, promoting the clarity about each other's expertise, roles and tasks, considering individual differences in needs, practices and challenges amongst their team members; To Stablish inter-professional programmes to develop an efficacy Leadership and Management Setting in Health and Social Care To create support systems for formal and family caregivers Training in staff and institutional managing to promote care of high quality and focus in the need of the subject of care. Promoting solid network, exchange of knowledge, and communication (communication systems), the research and innovation to promote knowledge and evidence based practice and quality decision making Institutional models for assessing health care staffing need to adapt professional/users ratios workforce needs identified by the sites: understanding the size and shape of the workforce for integration; designing and redesigning the existing workforce with the right values; skilling the workforce; developing a diverse market, focusing on workplace culture. Managing the ways in which work-related stress can impact on employees (e.g. physical and mental health, personal life, health behaviours such as	home-based care if is the preference of the individual Incorporation of the vision of the quality and outcomes of care, person-centered focus, outcomes and satisfaction, encouraging feedback, capturing and recording evidence of the effectiveness of care and using that as part of a feedback cycle to improve care. ncorporation of ethic, ranscultural and perspective of ocial determinants, gender and ocial inclusion and research and quality in the health and social are provision o facilitate collaboration between professionals and hence mprove care outcomes, with hared accountability and esponsibility, respecting and understanding roles: Sharing power, joint working, autonomy. establishing general practices that include generalists working alongside specialists in social care To promote the participation of all H&SP in the decision-making processes To promote the joint care planning and co-ordinated assessments of care needs. Named care co-ordinators who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey. Leadership and management with a clear leader of the team, with clear direction and management; democratic; shared power; support/supervision; personal development aligned with line management; leader who acts and listens; with communication skis Promote the learning, training and development; training and career development opportunities; incorporates individual rewards and opportunity, morale and motivation; focus in personal (knowledge, experience, initiative, reflexive practice) and interpersonal (listening,

for H&SP workforce strengthening; and Mechanisms to coordinate an intersectoral H&SP workforce agenda, if possible from a central workforce unit Education and capacity building plans aligned with national social care plan To involve H&SP in the designing and evaluation of staff policies	excessive alcohol consumption, and job performance) threaten wellbeing; with a focus in prevention and emotional support with of adequate respite and recovery time to maintain wellbeing and optimum job performance over the long-term; developing procedures to manage stress (reactively) and build resilience (proactively); Managers working with the following **attributes**: approachability; empathy, optimism, emotional literacy, self-awareness, self-confidence, and well developed reflective skills; etc. Managers need to support frontline staff to focus on outcomes for people, not on tasks or processes: empowerment, enhancement, engagement, enablement. Facilitates recruitment of staff who demonstrate interdisciplinary competencies including team functioning, collaborative leadership, communication, and sufficient professional knowledge and experience. H&SP participate in care guideline be developed to guarantee the quality of care	team work, etc.) skills and values Promote a good climate: Team culture of trust, valuing contributions, nurturing consensus; need to create an interprofessional atmosphere.

III. Care environment and service delivery

III-1 Care environment

Care environment is always a major concern in the field of social and health services. It is a complex system which encompasses both the objectively visible surrounding environment as well as the subjectively perceived environment (Wijk, 2019).

Objective aspects are measurable and comprise features such as accessibility, accommodation (the size of the room, whether it is clean or not, light or dark, hot or cold, if there are views and nature). The psychosocial environment refers to hospitality, warm, affection, response to the person-needs, the atmosphere and ambience in the room, the way it feels. Therefore, the same environment can be perceived completely

different by different people. In addition of public care facilities such as clinics, health centres, hospitals, dispensaries, mobile clinics, pharmacies, other types of care settings are developed including welfare services, care homes, day centers, and social network.

Vulnerable older people because of disability or disease are particularly dependant on an environment that can be easily understood and which contributes to security, independence and well-being. That is why one of the priorities of the health care system is to help seniors live in the comfort of their own homes and to create spaces for leisure, meetings and social communication to break their isolation and support their families.

A holistic approach of care environment takes into consideration individual socio-economic environment (social and cultural differences and preferences, housing, community services)

III-2 Service delivery

Service delivery in health care can be defined as the act of providing patient-centred services (Gilson, 2012). According to WHO (2010) health and social systems are only as effective as the services they provide. They shape the conditions that facilitate (or hinder) the provision of patient-centred integrated care in a region or country, as well as broader society (WHO, 2010).

The capacity of giving quality and effective services are related as having a center of the system that serves as enter point to the subject of care, this could the primary care level, having a harmonious coordination at horizontal and vertical levels (at the same and at different institutions and services). That allows to give an integrated range of health and social interventions that respond to the full range of conditions of the target populations, rules and standard practices to ensure accessibility and quality of care related to sustainability, safety, effectiveness, continuity, and people-centeredness, having mechanisms to involve the user in the design and planning of care, including planning and decision shared.

Ageing populations with multiple co-morbidities of chronic diseases such asNCDS, mental diseases, disabilities, are further challenges to social and health care systems. Globalisation is shifting the requirements for health care and control to reachacross borders. The global financial crisis is having a direct negative impact on the size,quality, reliability and population coverage of health services. Adapted model care

delivery must continue, in an uninterrupted and coordinated way, to address people's needs, not only as patients but also beyond, such as through prevention and monitoring

Definition of the levels of management

According to the UK Law Commission Review 2011 (Law Commissions Act, 1965) *adult social care was defined as "the care and support provided for those who need extra support; it includes traditional services such as care homes, day centers, equipment and home care and can extend to nontraditional services such as gym membership, arttherapy, personal assistants, emotional support, and classes or courses*".

According to WHO **health care systems** is "*divided into micro-, meso-, and macro-levels that provide a reasonable framework and refer to the patient interaction level, the health care organization and community level, and the policy level, respectively. Each of these levels interacts with and dynamically influences the other two*"(WHO, 2002).

For the TEC-MED project we considered both definitions in relation with the **Care environment and service delivery**.

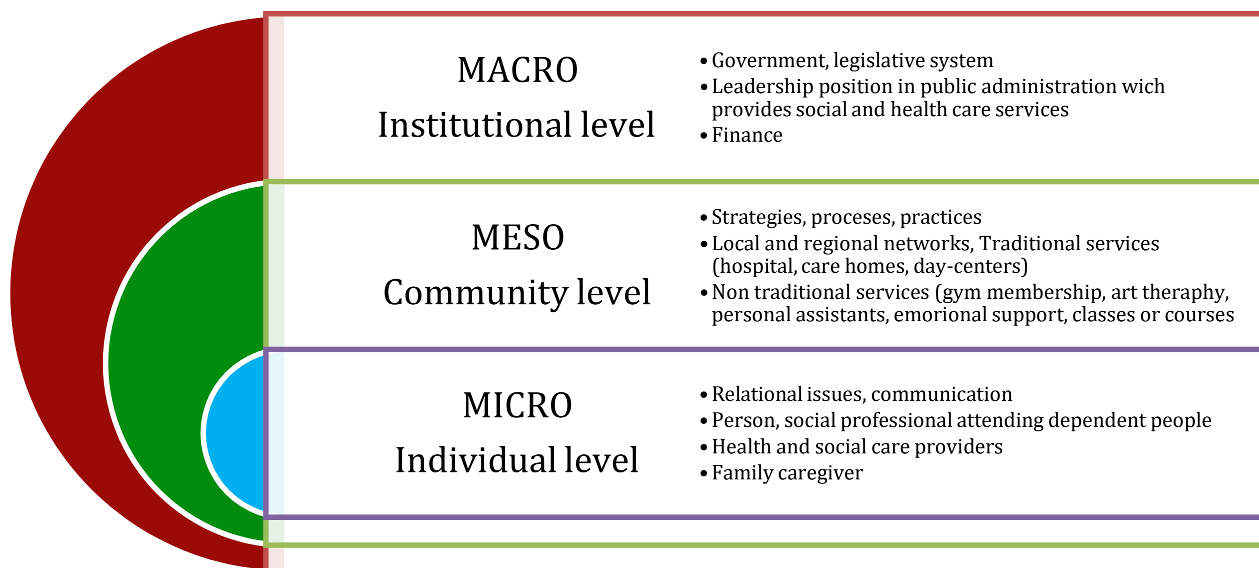

Figure 1: Management levels of care environment and service delivery

In the TEC-MED model we advocate for an integrated social and health care. The ideal is a perfect coordinated care that responds to all the patient needs and

preferences, from a holistic bio-psycho-social perspective, including the person in the care process with a person-centered vision.

The operationalization of the dimension is in the table 3.

Table 3: Operationalization of Care environment and Service delivery

Macro	Meso	Micro
Regulation of care environment and service delivery to: – Integrated service delivery systems to improve continuity and increase the efficacy and efficiency of services. – Tackle geographic inequalities in health care and social care. – Coordination between decision makers and managers of different organizations and services at local and regional level. – Implement coverage of basic needs guaranteeing universal rights (housing, health, medical treatment, retirement plan and pension). – Integration in a single model of social and health care, managed from the same body.	Strengthen multisectoral and inter-institutional collaboration in relation to the needs of the elderly. Strengthen the community and capacity action involving health and social services, care networks, meetings, leisure and social communication, financing. Involve community in care environment and service planning. Home environment will be of quality and adapted to the needs of a person that could have difficulties with carrying out some daily life activities. A supportive age-friendly infrastructure, i.e. environment with enough material and qualified human resources. Housing alternatives focused on the person's needs and preferences, which should be designed for elderly people who are unable to stay at home. Develop and implement specific protection programs for the elderly with disabilities Care environment at the primary level should be preventive and rehabilitative, available, with technology support, accessible, affordable, comprehensive, outcome - oriented and evidence-based, transparent, developing physical infrastructure. Choose the most appropriate level of care according to care needs and not based on the resources available in a sectorized area of care. Develop a standard approach to social and health ethics based on	Focus on the subject of care (person and family), including assessment of individual needs, stratification of care, individualized evidence-based plans with his/her involvement and participation in the care process including decision support. Implement integrated care, patient-centred, bio-psychosocial model, proactive. Assessment of individual needs, stratification of care, individualized evidence-based plans with his/her involvement and participation in the care process including decision support and shared, shared planning of care,. Empowerment, including multiple solutions, long-term care and palliative care Choose the most appropriate level of care according to care needs and not based on the resources available in a sectorized area of care. Unique way of access, case management, continuity between levels, family and community support. Take into account gender dimension by identifying gender and other inequalities and addressing gender equity regarding care environment and service delivery. Take into account cultural, religion and transcultural aspect in the service delivery Support research, data Collection and Development

	main ethical principles (autonomy, beneficence, non-maleficence, and justice). Care environment and service delivery will be adapted to different languages and culture aspects. Accreditation for the new care environment and service delivery developed within the TEC-MED project will be obtained. Develop and set up a guideline for good practices in service delivery.	Strategies to guide family members in goal setting activities related to supporting patients, teach family members supportive communication techniques and how to monitor symptoms and treatments associated with chronic conditions Early diagnosis and treatment while tertiary is rehabilitation. These efforts can encourage maintaining and/or adopting household health practices Develop caregiver Training Programs

IV. Financing

Financing is the economic support system of any model. The possibilities are: public, private, mixed or nonprofit. This term includes the financial and accounting system, financial sustainability, financial performance and other question relation with financial matters. This term includes the funding priorities at the political level and the government level.

Macro: Government and political level in terms of laws that maintain financial support E.g. pensions (an example is Takaful and Karama project from Egypt in collaboration with World Bank)

Meso: This means the intermediate levels of authority that facilitates transfer of economic support and creating financial support opportunities e.g. applying for grants, capacity building. In addition, designing and implementing systems e.g. health insurance piloting in Port Said City by the regional Health Insurance Authority

Micro: This is the level at the interface of target beneficiary i.e. the final step for financial support system or hierarchy e.g. geriatric houses, social solidarity employees and offices. The milestone for this level is the transparency and auditing that assures accurate delivery of required support in a user friendly approach.

To promote financing public, universal and transparency. Preferably promote public financing, without ignoring the public-private possibilities for the greater benefit of the recipients. Everything based on the principles of distributive justice, universality, transparency, fair communication and proper use of resources (efficiency). Transparent entrepreneurship concentrates on innovation, leadership responsibilities for performance achievement and joint financial agreements to guarantee the covering and integrated care.

Reviewing the different initiatives reveals the multi-layered nature of finance, e.g. encouraging achievement and joint financial agreements in ICARE4EU, which necessitate action on macro management level, same as in San Juan de Dios, where macro level intervention is sought to guarantee economy rights and BURTZORG for maintaining financial sustainability for elderly.

On the other hand, in Integrate, as a people centered approach, Financing and incentive, investing in an adequate workforce represents a good example on micro as well as meso level of financing.

In conclusion, financial domain plays an important role in the development of a successful model, however, the assurance of multi-levels of financial solutions and initiatives is mandatory to cover the different domains and needs. A model that creates sufficient funding resources (through macro management level e.g. official agreement and multinational partnerships) for empowering initiatives that targets vulnerable populations aiming to provide support on personal levels with assurance of sustainability and maintenance of finance and delivered through meso and micro level of management is invaluable.

The operationalization of the dimension is in the table 4

Table 4. Operationalization of Financing.

Macro level	**Meso Level**	**Micro Level**
– Universal access to services promoting social inclusion. – Territorial and political fiscal solidarity	– Decrease the cost rate of the institutionalization of the elderly as families prefer caring for their relatives in order to	– Collaboration with companies to fund different services in elderly care centers. – Developing an

<table>
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<td>– Coverage of basic needs guaranteeing universal rights (housing, health, etc.)
– Adequate financing system that favors social inclusion, eliminating copay (pharmaceutical, orthoprosthetic).
– Review of the criteria for economic participation of users with the elimination of the copayment.
– Incorporation of financing and public contracting of resources and services necessary for socio-health care
– Provide appropriate pension systems that offer support depending on the needs and situation of the elderly population. [
– Providing opportunities for financing, for instance: improve work access forand participation by people with chronic diseases, tosupport employers in implementing health promotion and chronic disease prevention activities in the workplace, and to reinforce decision-makers' abilities to create policies that improve access, reintegration, maintenance and stay at work of people with chronic diseases
– Ensure gender equity in financing Policies that are based on, and respond to, the practical and strategic needs of men and women can lead to more effective responses.
– Streamline management and promote urgent care to</td>
<td>avoid huge expenses. Entities focusing on community development should focus more on enhancing the current status of the elderly, especially in rural areas.

– Decommodification of socio-health care, without exclusively prioritizing the business benefit
– Control of companies regarding the quality of care
– Restriction of entry into the sector to speculative financial groups
– Incorporation of the culture of evaluation of process results and impact.

– Evaluate and control the quality of care in concerts</td>
<td>auditing system to monitor the delivery of required support to target population.
– User friendly approaches to support with preservation of dignity e.g Takaful and Karama [assurance of gender equality of delivery of support]
– Distribution of money taking into account the gender differences:
– Funding must be based on differentiated estimates incorporating women's values, contributions and time</td>
</tr>
</table>

those households that are in a situation of social emergency		

VI. Technology

In accordance with WHO (2019), digital social interventions aim to support population care, training, recording of the information, the alert notifications, communication and coordination, and for evaluating the quality of the care provided, and the policies.

The term technology1 spans different definitions and applications that include- but not limited to- telemedicine, tracing technology, data entry software and applications of Artifical Intelligence (AI) to predict risks. Again, adoption of technology in any model must be developed under the values of user-friendly, availability, accessibility, etc. It is considered that digital social interventions should be accessible at a minimun via mobile devices.

Additionally, transversal concepts of the TEC-MED Model should be taken into account, such as quality, research and dissemination, gender perspective, ethical aspects, social inclusion and transculturality. This means that TEC-MED model should be linked to aspects such as respectful human rights and dignity, person centered, preventive and rehabilitative, available, accessible, affordable, comprehensive, taking into account the transparency, gender and the culture. Furthermore, it is considered very important to share research/good practices results with potential users-peers in different fields (research, industry, policymakers) and transfer.

It seems important to highlight, in the context of the use of technology, compliance with bioethical principles related to privacy, confidentiality and empowerment, in addition to those already known, autonomy, beneficence and justice.

Another aspect which should be kept in mind is related with the technological gap, so the model should guarantee access to technological solutions by facilitating the social inclusion of the target users of the model.

In addition, it should be kept in mind the transverse involvement of different levels of management in developing and endorsing technological solutions or innovations i.e.:

- Macro: National support policies to improve the technology development and the innovation. Guaranteeing the equitative access, availability and freely available of the technology services. Impact of technology on the economic and social protection systems, and the health and social care systems Cultivating diversity and promote inclusion while respecting cultural, ethnic and gender differences
- Meso: Use of technology to coordinate the services. The coordination is possible at a local level by the City Council's health and social services or by private or nonprofit entities. Impact on organizations, interoperability, and health and social providers
- Micro: Use of technology to improve the well-being of the target population, e.g. telemedicine, telemonitoring. Technology support to family caregivers. Technology support to healthcare providers (training, recording, follow-up). Impact on careers and care recipients

Implementation of technological solutions can be observed in the different successful initiatives reviewed, most pronounced in tracking and follow-up (COMUNITÀ MONTANA GRAND PARADIS- Italy; Aging Lab Worthy and Positive Aging Model, EDP- Spain; as well as SELFIE and INTEGRATE –EU). In addition, emerging tele-medicine solutions are emerging as a valid and valuable alternative (partially) especially in situations like COVID-19, this has been traced as well in (COMMUNITY OF S EGIIDIO “Long Live the Elderly!”- Italy and San Juan de Dios-Spain [providing HIS TICARES: management of care and professional, users training]).

An interesting application for AI has been in development stage at the Institute of the global Health and Human Ecology (I-GHHE), in Egypt, where through collaboration between different partners (EGY, US, EU), an AI developed model can be used to assess the degree of cognitive impairment based on data derived from social media activities for elderly subjects that can provide a risk assessment strategy for early detection of dementia or MCI.

In conclusion, the introduction of technology is one milestone for a successful model on different fronts, management, follow up and risk prediction. The successful adoption of technological innovations/solutions however, depends on the integrated approach between different levels of management starting from regulations and laws

set by macro level, active implementation on meso-level, and finally participation and engagement with target population through micro level of management.

Based on the previous lessons learnt from different promising initiatives in the partner countries, we can suggest the following approaches for Technology to be implemented in TEC-MED Model (table 5)

Table 5. Operationalization of technology

Macro	**Meso**	**Micro**
Laws that facilitates implementation of technologies in care is essential to control this emerging practice. Eg privacy of data, regulations for remote medical consultation (to what extent, what is acceptable and what is not). [Acceptance of transcultural difference] AND[laying foundation for ethical basis] Investment in socio-educational interventions to improve the skills of the group in order to improve their autonomy, including digital competence Invest in technology and trial innovative ways of supporting clients and their families Smart city initiatives (adult social care chat bot, an in-house development that is designed to provide people with adult care information 365 days a year; collaborative	Promote collaborative work between the different institutions for better use of available technological resources through the exchange of information and experiences Implementation of technological solutions for tracking and follow-up, tele-medicine especially in situations like COVID-19, providing social and health care history, management of care and professional, users training]. Detailed database of elderly with their files (medical, social), social and health services Staff and resources management systems Evidence based tools and clinical	Improve the environmental conditions so that they help and favor the equitable use of technology. Customize technologies to allow greater accessibility for all users. Promote digital literacy to help develop technical and social skills in the use of technology Promote the integration of people as critical and active subjects, and not as mere consumers of technologies and digital content (Travieso, J.L. & Planella 2008) Use of app for assessment, for instance, assessing the cognitive impairment based on data derived from social media activities for elderly subjects that can provide a risk assessment strategy for early detection of dementia or MCI. Remote medical consultations and well-being (smart app) for elderly (for example, Doktori Platform, Egypt). Telehealth for cognitive behavioural therapy Use of ICT for Electronic treatments to decrease social isolation/loneliness for older people living in the community/residential care. Social tools (e.g. online forums, video-chats) that address both personal and social integration needs assist the family carers to reduce their social isolation as well as improving their social activities and intergenerational relationships (ej. Action, in Sweden (Bergström et al., 2010); Cuidadoras en Red, in Spain (Carrión and Armayones 2006). The

maps which as well as tracking the most appropriate route for a pedestrian's needs; smart beches) Economically accessible tic tools (smartphone, tablet) Promotion technology at national level, for instance Nationwide Health Information Network (NwHIN)	decision support systems	"IPPI", in Sweden (Östlund and Lindén 2011).) ICTs for independent living that help family carers to reconcile care and work(such as "Action", "E-Care", "Emergency Alarm", "IPPI", "Just Checking", "Sophia", and "Telecare Scotland") Person Centred software for care home (Mobile care Monitoring resindecial care, nursing homes, supported living, learning disabilities, mental health support (Person Centred Software, 2020) Adapted tic courses to facilitate access to program and services (Marziali & García, 2011) Web-based Electronic health records (EHR) system that offer various benefit for both patients and doctors and increase efficiency and better quality of care (WHO, 2007; Bajwa, 2014)

VI. Governance

Governance is the process by which social care organizations guarantee good service delivery and foment positive outcomes for people who use services. It consists in a wide range of steering and rule-making related functions carried out by governmental/decisional makers. Governance is oriented to develop implementation and change strategies tailored to different care settings and contexts in Europe and Mediterranean area.

As identified in the TEC-MED model document, for the macro level, good governance should be oriented to be independent from political orientation, guaranteed by fair financing and with the development of legislation that universally protects with equity, throughout the national territory, all citizens regardless of their resource. An optimal governance model should count on a strong coordination network, of all actor's levels and resources. From the meso level, policy and action plans and political commitment are aimed at protecting the ethos of autonomous practice, integrated care programs, community-based practice, high levels of client and staff satisfaction, financial sustainability, customer empowerment and comprehensive care

with a primary focus on clients with complex health and social issues care needs. Autonomy, in fact, is a key variable for a profound transformation, it also includes accountability mechanisms (to political groups, regulatory bodies, local authorities, boards of directors and the general population), changes in the status and roles of human resources and the impact on social health information systems.The health service providers follow a performance-based management and creating individualized care planning coordination tailored to complexity, counting on less bureaucracy and offering all support functions. In this sense, the citizen is a primary and active actor in the choice of care policies sharing decision-making.

Definition of the levels of managements

For the TEC-MED model we considered three levels in relation with the governance:

- **Macro**: the State (government organizations and agencies at central and sub-national level)
- Meso: the health service providers (different public and private areas for and not for profit clinical, para-medical and non-clinical health services providers; professional associations; networks of care and of services)
- Micro: the citizen (population representatives, patients' associations, CSOs/NGOs, citizen's associations protecting the poor, etc.) who become service users when they interact with health service providers.

The operationalization of the dimension is in the table 6.

Table 6. Operationalization of Governance

The State	The Health Service Providers	The Citizen
Establishment of active committees which support the national strategies for old age and related projects and initiatives while enforcing political commitment to old age matters and taking into	Active participation of service providers in the design of laws and policies for dependent elderly and/or at risk of social exclusion taking into account ethical, transcultural, gender	Active participation of population representatives, patients' associations, CSOs/NGOs, caregivers and family members in the design of laws and policies for dependent elderly and/or at risk of social exclusion taking

account ethical, transcultural, gender and social inclusion aspects Establishment of policies, action plans and initiatives oriented to integrate the health and social care and services Initiation of needs assessment activities for older age at the national level to get data about older' needs of care. Building age friendly public policy standards and procedures. Creation and design of age friendly cities. Establishing good governance systems within governing organizations. Involving stakeholders in the design of programs and policies which promote multi-sectoral partnerships, governance and accountability. Working on strategies and standards for population health management and specialized geriatric health care. Involving stakeholders in building awareness on the importance of good governance, transparency and leadership. Active presence, involvement and collaborative commitment of leaders in community programs. Supporting new laws and policies which protect the rights of older adults and support the concept of active and positive aging. Networking with local organizations (health and other) and local	and social inclusion aspects. Involvement in quality health-related research for old age and to identify the needs and gaps of old age care while sharing results with the state and the community while taking into account ethical, transcultural, gender and social inclusion aspects Training of service providers on good governance systems, performance-based management, and leadership. Providing comprehensive health care focusing on older adults' health and social needs while setting important indicators such as satisfaction from services, integrated care, financial sustainability, etc ... Participating in high-level individualized care planning and coordination with local and national bodies. Building awareness on good governance, transparency and leadership. Advocacy efforts for the (health and social) needs and rights of older adults. Networking efforts with local and national committees for better governance of old age programs.	into account ethical, transcultural, gender and social inclusion aspects. Involvement and collaboration in local community governance programs. Training on good governance practices, leadership, transparency and accountability. Involvement in monitoring and evaluation practices for quality assurance of old age care. Involvement in advocacy and awareness projects to address the needs of older adults. Participation and collaboration in old age research efforts on the local and national levels. Networking with health service providers and national committees for better governance of old age programs.

communities to manage and develop old age programs. Empowering local organizations to address the needs of older adults and demonstrate good governance practices. Improvement of training of health and social care providers at the national levels. Establishing a governing body for monitoring and evaluation measures as well as quality assurance protocols for older age care.		

REFERENCES

Annual Report Sarah Soueidan, Hibah Osman, & Fadi El-Jardali. K2P Policy brief. (2018). Integrating Palliative Care into the Health System in Lebanon. American University of Beirut.Faculty of Health Sciences. Knowledge to Policy K2P Center Askunze, C. (2013), “Más allá del capitalismo: alternativas desde la Economía Solidaria”, Documentación Social, no 168.

Baltes P.B. y Baltes, M.M. (1990). Success fulaging: perspectives from the behavioral sciencies. Cambridge University Press.

Baltes, M.M. y Wener, W. (1990). Dependencia en los ancianos. En Carstensen y Edelstein (1990): Gerontología clínica: intervención psicológica y social.

Bajwa, M. (2014). Emerging 21st Century Medical Technologies. *Pakistan Journal of Medical Science*. 30 (3): 649–655. doi: 10.12669/pjms.303.5211

Barrientos-Trigo S, Vega-Vázquez L, De Diego-Cordero R, Badanta-Romero B, Porcel-Gálvez AM (2018). Interventions to improve working conditions of nursing staff in acute care hospitals: Scoping review. J Nurs Manag. 26(2):94- 107. doi:10.1111/jonm.12538

Benner, P., Pearson, A., Watson, J., & Rolfe, G. (2003). *Theory and Practice of Nursing. An integrated approach of caring practice* (L. Basford & O. Slevin (eds.); 2nd ed.). Nelson Thornes.

Bergström M, Modin B, Fransson E, Rajmil L, Berlin M, Gustafsson PA, Hjern A. (2013). Living in two homes-a Swedish national survey of wellbeing in 12 and 15 year olds with joint physical custody. BMC Public Health. Sep 22; 13:868. doi: 10.1186/1471-2458-13-868. PMID: 24053116; PMCID: PMC3848933.

Borgermans, L., & Devroey, D. (2017). A Policy Guide on Integrated Care (PGIC):

Lessons Learned from EU Project INTEGRATE and Beyond. International Journal of Integrated Care, 17(4), 8.

Brañas, F., Azcoaga, A., García Ontiveros, M., & Antela, A (2018). Cronicidad, envejecimiento y multimorbilidad. Enfermedades Infecciosas y Microbiología Clínica. 2018; 36(1), 15–18.

Cash-Gibson, L., Tigova, O., Alonso, A., Binkley, G., & Rosenmöller, M. (2019). Project INTEGRATE: Developing a Framework to Guide Design, Implementation and Evaluation of People-centred Integrated Care Processes. International Journal of Integrated Care, 19

Castrillón, E. (2015). La enfermera transcultural y el desarrollo de la competencia cultural. Cultura de los Cuidados, 42, 128-136.

Chacín, B. (2008). Modelo teórico-Meodológico para generar conocimiento desde la extensión universitaria. *Revista de Educación Médica*, *14*(26), 56–88.

Consejería de Igualdad, Políticas Sociales y Conciliación de la Junta de Andalucía. (2019). Estrategia de Ética de los Servicios Sociales. Retrieved from: https://www.juntadeandalucia.es/export/drupaljda/publicacion/19/05/Estrategia%20de%20Etica%2027%2005%202019.pdf

European Commission. Dissemination and Exploitation of results. Retrieved from: https://ec.europa.eu/research/participants/docs/h2020-funding-guide/grants/grant-management/dissemination-of-results_en.htm. (Accessed June 27, 2020).

European Committee for Social Cohesion (2004). A new strategy for Social Cohesion. Retrieved from: https://www.coe.int/t/dg3/socialpolicies/socialcohesiondev/source/RevisedStrategy_en.pdf (Accessed June 27, 2020).

Eurostat Statistics Explained. (2018). *Archive: People at risk of poverty or social exclusion*. European Committee. https://ec.europa.eu/eurostat/statistics-

explained/index.php?title=Archive:People_at_risk_of_poverty_or_social_exclusion.

Fawcett, J. (2013). Analysis and Evaluation of Nursing Theories. In *Contemporary Nursing Knowledge : Analysis and Evaluation of Nursing Models and Theories* (p. Cap. 3). Philadelphia: Davis.

Fernández Ballesteros, R. (1996). Evaluación eIntervención psicológica en la vejez. Madrid. 1996.

Fundación Pilares. Memoria de resultados año 2018. www.fundacionpilares.es [visited 23/06/2020]

Gilson L, ed. (2012), Health Policy and Systems Research: A Methodology Reader Alliance for Health Policy and Systems Research World Health Organization.Pages 19-40. Available at: https://www.who.int/alliance-hpsr/resources/alliancehpsr_readerpart1.pdf).

González MJ y Valderrama E. (2001). *La práctica de un modelo es una práctica con valores*. Asociación Española de Enfermería Docente.

González-Ortiz, L. G., Calciolari, S., Goodwin, N., & Stein, V. (2018). The Core Dimensions of Integrated Care: A Literature Review to Support the Development of a Comprehensive Framework for Implementing Integrated Care. International Journal of Integrated Care, 18(3), 10.

Grant, L., Kinman, G. (2015). *How do good social work managers promote staff wellbeing?.* Recovery from; https://www.communitycare.co.uk/2015/06/24/good-social-work-managers-promote-staffs-wellbeing/

Leijten, F., Struckmann, V., van Ginneken, E., Czypionka, T., Kraus, M., & Reiss, M. (2018). The SELFIE Framework for Integrated Care for Multi-Morbidity: Development and Description. *Health Policy*, *122*(12), 1–22.

Health Promotion Programs for the Elderly in Greece, the “Health Pro Elderly” Project, Sourtzi P, Roka V, Velonaki V, Kalokerinou A, 2010

Ley 39/2006, de 14 de Diciembre, de Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia. Dependencia

Leturia, F.J., Yanguas, J.J., Uriarte, A. y otros (2001). La valoración de las personas mayores:evaluar para conocer, conocer para intervenir.Cáritas Española. Madrid.

Lebanese Center for Palliative Care- Balsam. (2018).Journal of Integrated Care. 19(4):494.

Leijten, FRM, Struckmann, V., van Ginneken, E.,Czypionka, T., Kraus, M., Reiss, M...on behalf of the SELFIE consortium (2018). The SELFIE framework for integrated care for multi-morbidity:Development and description. Health Policy, 122, 12-22

Leininger, M.M. Part I. (2002). The theoryof culture care and the ethnonursingresearch method. In: M.Leininger & M.R.McFarland (Eds.), Transculturalnursing: Concepts, theories, research and practiceNew York:McGraw-Hill Medical Publishing Division. pp. 71-98.

Liotta, G.; Inzerilli, M.C.; Palombi, L.; Madaro, O.; Orlando, S.; Scarcella, P.; Betti, D.; Marazzi M.C (2018). Social Interventions to Prevent Heat-Related Mortality in the Older Adult in Rome, Italy: A Quasi-Experimental Study. Int. J. Environ. Res. Public Health, 15, E715.

Liotta, MC Inzerilli, L Palombi, A Bianchini, L Di Gennaro, O Madaro, et al Impact of social care on Hospital Admissions in a sample of community-dwelling older adults: Results of a quasi-experimental study. Ann. Ig 30, 378-386

The Law commission (Law Com No 326. Adult social care. Presented to Parliament pursuant to section 3(2) of the Law Commissions Act 1965. Available at: http://www.lawcom.gov.uk/app/uploads/2015/03/lc326_adult_social_care.pdf

Lueders, Beth. American Society on Aging, (2017). www.asaging.org

Martínez Roca, Madrid.Fernández Ballesteros, R. (1997). Sistema de evaluación de residencias de ancianos (SERA). IMSERSO. Madrid.

Martínez Roca.Leturia F.J. y Yanguas, J.J., (1998). Interven-ción psicosocial en gerontología: manual prácti-co. Caritas Española, Madrid.

Marazzi, MC Inzerilli, O Madaro, L Palombi, P Scarcella, Orlando S, Maurici M, Liotta G (2015). Impact of the Community-Based Active Monitoring Program on the Long Term Care Services Use and In-Patient Admissions of the Over-74 Population. Advances in Aging Research, 4, 187-194

Martins A, Da Silva L, Corrêa L, Rosset I, Peroni C, Partezani R. (2013) Functional dependency of older individuals and Caregiver Burden. Rev Esc Enferm USP. 47(1):134–41

Martínez T. Ante la crisis del COVID-19: Una oportunidad de un mundo mejor. Declaración en favor de un necesario cambio en el modelo de cuidados de larga duración de nuestro país. Recuperado de http://acpgerontologia.blogspot.com/2020/04/ante-la-crisis-del-covid- 19-una.html Published online April 1, 2020.

Marziali, Elsa & Garcia, Linda. (2011). Dementia Caregivers' Responses to 2 Internet-Based Intervention Programs. American journal of Alzheimer's disease and other dementias. 26. 36-43 10.1177/1533317510387586.

Montorio I. & Izal, M. (1999). Gerontología con-ductual: intervención y ámbitos de aplicación. Sín-tesis. Madrid

Montorio,I. (1995). La atención psicológica. EnP. Rodríguez (de): Residencias para personas mayores. Manual de Orientación. S. G., Madrid.

Montorio Cerrato, I., y Losada Baltor, A. (2004). Una visión psicosocial de la dependencia desafian-do la perspectiva tradicional. Perfiles y tendencias octubre 2004. Madrid: IMSERSO.

Moos, R.H. (1979). Evaluating Educational Environments: Procedures, Measures, Findings,and Policy Implications.

Munthe, C., Sandman, L. and Cutas, D. (2012). Atención centrada en la persona y toma de decisiones compartidas: implicaciones para la ética, la salud pública y la investigación. Health Care Anal 20, 231–249.

Murphy, S. C. (2006). Mapping the literature of transcultural nursing. *Journal of the Medical Library Association: JMLA, 94*(2 Suppl), E143–E151.

North American Nursing Diagnosis Association (2020)

Nancarrow, S. A., Booth, A., Ariss, S., Smith, T., Enderby, P., & Roots, A. (2013). Ten principles of good interdisciplinary team work. *Human resources for health*, *11*, 19. https://doi.org/10.1186/1478-4491-11-19

NSW Government Health (2014). Multidisciplinary Team Care. Recovery from: https://www.health.nsw.gov.au/healthone/Pages/multidisciplinary-team-care.aspx

Øvretveit, J. (2017). Digital Technologies Supporting Person-Centered Integrated Care – A Perspective.International Journal of Integrated Care, 17(4), Orden Hospitalaria de San Juan de Dios. (n.d.). *Orden Hospitalaria de San Juan de Dios*

Person Centred Software (2020). Mobile Care Monitorin. Recovery from: https://personcentredsoftware.com/gb/

Peterson, S., & Bredow, T. (2009). *Middle range theories. Aplication tu nursing research* (2nd ed.). Lippincott Williams & Wilkins.

Palmer, K., Carfì, A., Angioletti, C., Di Paola, A., Navickas, N., Dambrauskas, L., ... Onder, G. (2019). A Methodological Approach for Implementing an Integrated Multimorbidity Care Model: Results from the Pre- Implementation Stage of Joint Action CHRODIS-PLUS. International Journal of Environmental Research and Public Health

Palombi L, Liotta G, Emberti Gialloreti L, Marazzi MC. Does the COVID-19 pandemic call for a new model of elderly care? Frontiers, in press.

Pike, B., & Mongan, D. (2014). *The integration of health and social services*. Dublin: Department of Health Raile M. (2017). *Nursing theorists and their works* (9th ed.). ElSevier.

Vykopalová, H (2016). Social risk management as a strategy in the fight against poverty and social exclusion. Danube: Law and Economics Review 7 (2): 123-129

Rodríguez, A., & Cruz, A. J. Modelo EDP (2016). Envejecimiento Digno y Positiv Cuaderno 0. Cuidados. Jaen: Againg Lab; 2016

Silvaggi, F., Eigenmann, M., Scaratti, C., Guastafierro, E., Toppo, C., Lindstrom, J., Leonardi, M (2020). Employment and Chronic Diseases: Suggested Actions for The Implementation of Inclusive Policies for The Participation of People with Chronic Diseases in the Labour Market Int. J. Environ. Res. Public Health, 17, 820;

San Francisco, Jossey-Bass.Yanguas, J.J. y Leturia, F.J. (1995a y 1995b). Intervención con familias. En AA.VV. Residencias para personas mayores. Sociedad Española deGeriatría y Gerontología, Barcelona.

Sourtzi P, Melchiorre MG, Lamura G, Barbabella F, on behalf of ICARE4EU Consortium (2018) eHealth for people with multimorbidity: Results from the ICARE4EU project and insights from the "10 e's" by Gunther Eysenbach. PLoSONE 13(11)

Travieso, J.L. & Planella, J. (2008). L'alfabetizació digital com a factor d'inclusió social: una mirada crítica. Uocpapers. https://www.uoc.edu/uocpapers/6/dt/cat/travieso_planella.html

Tucker, C. M., Marsiske, M., Rice, K. G., Nielson, J. J., & Herman, K. (2011). Patient-centered culturally sensitive health care: Model testing and refinement. Health Psychology, 30(3), 342–350. https://doi.org/10.1037/a0022967

United Nations (2002). Madrid International Plan of Action of Ageing 2002. Retrieved

from: https://www.un.org/development/desa/ageing/madrid- plan-of-action-and-its-implementation.html (Accessed June 27, 2020).

Van der Heide, I., Snoeijs, S., Melchiorre, M. G., Quattrini, S., Boerma, W.,...Rijken, M. on behaf of the ICARE4EU Project team. (2015). Innovating care for people with multiple chronic conditions in Europe. An overview.

Wijk H. (2019). Health Care Environment. Supportive care and stimulating environments for health and well-being. Institute of Health and Care Sciences,University of Gothenburg. Available at: https://caresci.gu.se/english/research/research-groups-/Care+Environment+

World Health Organization (N.D). *Towards a sustainable health workforce in the WHO European Region: framework for action. Recovery* from: https://www.euro.who.int/en/health-topics/Health-systems/health-workforce/towards-a-sustainable-health-workforce-in-the-who-european-region-framework-for-action

World Health Organization. (2002). Active Ageing: A Political Framework. Rev Esp Geriatr Gerontol;37(S2):74-105

World Health Organization (2002). WHO Innovative care for chronic conditions: building blocks for action. Global report. Library Cataloging-in-Publication Data. WHO/MNC/CCH/02.01.

World Health Organization (2007). The Sixtieth World Health Assembly. Health Technologies. Recovery from: https://www.who.int/healthsystems/WHA60_29.pdf

World Health Organization (2019). *National Health Workforce Accounts (NHWA) Resource pack for the WHO European Region (2019).* Recovery from; https://www.euro.who.int/en/health-topics/Health-systems/health-workforce/towards-a-sustainable-health-workforce-in-the-who-european-region-framework-for-action/national-health-workforce-accounts-nhwa-resource-pack-for-the-who-european-region-2019

World Health Organization. (2010). Key components of a well functioning *health system*. https://www.who.int/healthsystems/publications/hss_key/en/

World Health Organization (2010). Policy summary prepared for the Belgian EU Presidency Conference on Investing in Europe's health workforce of tomorrow: scope for innovation and collaboration (La Hulpe, 9–10 September 2010) https://www.euro.who.int/_data/assets/pdf_file/0019/124417/e94295. pdf

World Health Organization (2010), on behalf of the European Observatory on Health Systems and Policies. Health Systems in Transition: Template for authors. Available at: https://www.euro.who.int/_data/assets/pdf_file/0003/127497/E94479.pdf

World Health Organization (2019). WHO guideline: recommendations on digital interventions for health system strengthening. Geneva: World Health Organization. Licence: CC BY- NC-SA 3.0 IGO.

World Health Organization. Ageing and Life Course. 2020. Disponible en https://www.who.int/ageing/en/).

World Health Organization. Health topics. Retrieved from: https://www.who.int/health-topics/gender (Accessed June 27, 2020).

Yur'yev, A., Leppik, L., Tooding, L.M., et al (2010). Social inclusion affects elderly suicide mortality. Int Psychogeriatr;22(8):1337-1343.

Annex 1. Analysis of themes in the most promising initiative in relation with the dimensions of the TEC-MED Model

Table 1. Analysis of themes in the most promising initiative in relation with the dimensions of the TEC-MED Model

BASIC DESCRIPTION				DIMENSIONS					
Context/ country	**initiative**	**Framework**	**Person**	**Health /social care provider**	**Care environment Service delivery**	**Governance**	**Financing**	**Technology**	**Transversal**
EU	Sustain	Integrate person-centred Dimensions: Prevention, safety, efficiency, coordination	Older people Informal careers	Multi and interdisciplinary teams	Home supportive environment, Build and strengthen community capacity and action, Prevention, Proactive assessment, Safety, Efficiency, Coordination Person involvement, Decision support, Self-management/person al skills	Build healthy public policy		Yes, as facilitator	

EU	Integrate	Integrate care People- Centred Dimensions: professional, clinical, systemic, organisatio- nal and normative integration	Older person, chronic conditions self-care, carer support,	Multi and interdisciplinary teams: Shared accountability and responsibility, formal agreements, training, collective incentives	Assessments and planning, named care coordinators for continuity of care, proactively manage the needs, a single point of entry, shared decision-making/care planning volunteers and community actively involved Common measures and outcomes, continuous improvement, written procedures	Stakeholders involvement in design programs and policies, policies promote multi-sectoral partnerships, governance and accountability Emphasis on population health management, Building awareness and trust, Presence of leaders	Financing and incentive, investing in an adequate workforce	10 Recommend -dations to guide building and improving DGT for CC& IC	

EU	SELFIE	Integrate care Person-centred Micro, meso y macro level Dimensions: workforce, Community and informal care, delivery system, leadership and governance, financing, technology and medical products, information & research	Individual with multimor-bidity and socio-economic environment wellbeing, needs, preference	Emphasizes Multidisciplinary care Communication	The environment includes welfare services, housing, social network, transport, financing, community Emphasizes: Coordinated Proactive, patient involvement, capabilities, self-management, Bottom-up	It is included	It is included	IT is included	
EU	CHRODIS	Integrated model Person-centred Dimensions: Delivery system design, decision support, self-management support, clinical information system, community resources	Individual with multimorbidity		community resources clinical information system, community resources, decision support, self-management support				

EU	ICARE4EU	Integrative model Dimensions: patient-centred, delivery system, performance management, quality of professional care, interprofessional teamwork, roles and tasks, commitment to IC, transparent entrepreneurship Includes micro, meso, macro levels	Individuals with multi-morbidity, self-management support , adjustment to needs	Need for clarity about each other's expertise, roles and tasks in the care chain is reflected by this element. Effective collaboration at all levels	Multidisciplinary care pathway throughout the care chain, based on evidence-based guidelines and standards and clients' needs and preferences. Chain and client logistics, coordination mechanisms and procedures, reaching agreements, procedures or tools Measurement and analyses of the results Indicators address client outcomes, client judgments, organizational outcomes and financial performance data. Feedback mechanisms and improvement team	Commitment to integrated care is on collaborative commitment and ambition in the care chain. Transparent entrepreneurshi p, leadership responsibilities for performance	achievement and joint financial agreements		

EU	WEDO	Person-centred Improving quality of services Fight elder abuse 11 Quality principles 6 Core concepts	Empowerment of elderly people Participacion		Quality of environment Preventive and rehabilitative Available Accessible Affordable Comprehensive Outcome oriented and evidence based Transparent Prevention (abuse, neglect) Developing physical infrastructure Partnership approach	System and good government	Investing in human capital		Respectful human rights and dignity Gender and cultures sensitive

Netherlands (active in 24 countries)	BURTZORG (neighbourhood care)	Holistic integrated care enabled people to live in their community for longer Ohama System	All ages Primary focus on clients with complex health and social needs	Public health and community nursing from a multi-disciplinary use/understood by others ethos of autonomous practice, High levels of satisfaction	Easy to understand terms and structures Informal/formal networks Whole care-process, assessment, intervention and outcomes Comprehensive practical classification system relationship based practice Holistic approach Self-management and empowerment High levels of satisfaction		Financial sustainability		
egipt	Takaful and Karama (Ministry of Social Solidarity)	Conditional and unconditional cash transfer program consists	Family income support Social protection		The dignity protects poor elderly citizens (above 65) with a monthly pension		Investing in human capital development		

egipt	SEKEM	Sekem Elderly Care Model (preparation, implementation and knowledge implementation and transfer) Domains: integration, follow up, recommendations, assessment, coordination	Olders (above 60) who live alone or with caregiver, multiple health and social care challenges, Empowering elders and caregivers	Involvement of professionals from multiple disciplines (health care and social care) There were identified relevant local stakeholders related to the initiative to create local steering groups for the implementation and the study	Sekem Medical Center conveys with stakeholders in the 13 villages surrounding the medical centre implementation single point of contact such as the medical center which is offering various options to communicate with professionals Multidimensional geriatric assessment Elderly Care Booklet aims to develop a series of evaluations and practices (recommendations) in the form of a handbook Proper assessment covers different issues of their lives Coordination evaluation criteria sets		Software for collecting patient's status and history		Efficiency

					Integration of elderly in choosing the proper care model that suit their lives Delivery of multiple solutions Follow up with elderly on regular basis to avoid future problems.				

Greece	KAPI Open Care Centres for Older People “Health pro Elderly”	Senior Health Mentoring for spreading out health promotion issues	Olders (above 60)	health and social care profes- sionals, such as nurses/health visitors, social workers, physiotherapist s, occupational therapists, home care assistants	develop evidence-based guidelines and recommendations Mobility, autonomy and self-care (exercise program)				

italy	COMUNITÀ MONTANA GRAND PARADIS 13 municipalities	Person-centred and long-term care	Biography of the elderly and the family Maximum family participation insertion to the day of life; take care of families,	Coaching for operators assigned to services Socio-health workers Auxiliary service operators Social workers Health workers	Municipalities Regional local health unit Voluntary associations, community operators Residential structure Home care services organizational planning structure with an articulated intervention Training process and implementation of individualized assistance plans Scientific approach to services, based on the programming, measurement and correction of interventions Focus on maximizing the quality of service	Triple link: quality, cost of service, wellbeing of caregivers (contracts, equity, training, participation) Specialization in organizational solutions: technical-political working group, responsible for the services		Monitoring during working hours to regulate operator overload	

italy	COMMUNITY OF S EGIIDIO “Long Live the Elderly!” Multiregional	Social and health integration	Frail individuals	Community nurses Social workers Training sessions	multidimensional assessment of bio-psycho-social frailty Population stratification Individualized care plan Periodical evaluation Integrated care from the bottom building up a network of social relationship	The program implementation needs the agreement of the local municipality where is adapted the program by implemented a program headquarter.		Telemedicin e ICT environment aimed at facilitating social connections and integration	
libanon	Balsam	Holistic and interdisciplinary approach	People with serious illness that needs palliative care Three patient categories: standard care, distance support, one-time visits.	Multidisciplinar y team with specialization in palliative care Strengthen education and training in palliative care among health professionals	Integrate palliative care services within health care facilities Provide palliative care at patients’ residence Medical services, psychological, social, practical and spiritual support, relieve the suffering and improve the QoL	Improve public awareness about palliative care			

libanon	IDRAAC + MEPI Municipality of Byblos-Jbail	"Elderly Empowerment Project". Alzheimer's Caregivers Training program	Elderly person (preventing social isolation) Olders that suffer from Alzheimer	Training men and women who do not have prior nursing education to become certified caregivers for Alzheimer's	Companies and associations within the jurisdiction of the Municipality work opportunities, volunteering opportunities and leisure activities for adults aged 60+. Integrating the elderly into the community at large to decrease their social isolation and empower them socially and financially support Support patients and their families at home.	New law which protects the elderly of Lebanon from discrimination and neglect following a comprehensive legal review of the laws related to the elderly in Lebanon			

libanon	SANAD	Hospice care	Person that needs palliative care	Capacity Building of staff Raising activities at the levels of the community and the medical and nursing profession	Three categories: medical care, mental health care and hospice care for terminal illnesses. Buy-in is essential for the creation of a supportive environment for advocating Holistic approach addresses any medical, social and psychological challenges patients and their families					

spain	Matía Foundation	Psycho-social intervention model. Integrative care Person-centred Dimensions: : prevention, assessment, empowerment, alternative resources	Elderly and their families	Multidisciplinary approach influence of the surroundings	Residential care model Open to the community Participation and community approach Fully satisfy the expectations STRATEGY: - Stimulation - Guidance - Emotional support - Health and functional support - Social support - Family support Integrative				guaranteeing and promoting rights maximum effectiveness and efficiency. Intimacy and autonomy Quality of life approach

spain	Aging Lab Worthy and Positive Aging Model, EDP	Biopsychosocial model Integrative care Person Centred Phenomenological -existential model Dimensions: Bioethics, Active Participation, Well-being, Collaborative Intelligence and Co- responsibility.	Elderly and careers	Enriched by professional expert knowledge, free praxis, balanced, symmetrical and harmonic specialization human development, Social ethics committees	Institutional, care at home Bottom up with the contribution of the different agents involved, Preventive, hholistic and participative perspective opening to the life and affective bonds Co-responsibility, universal accessibility, creative commons, integrative and interdisciplinary, coordination, creativity and innovation , results and continuous improvement, Balance, systematization, implementation, connectivity and progressivity			technology,	justice, privacy and confidentiality , autonomy and empowerment , wellbeing, diversity from equality

spain	San Juan de Dios	Integrative care. Dimensios: person, decision making, vital course	General population	Professional secrecy, attribute and professionalism, participation in the order mission,	Responsibility, quality, efficacy and efficiency		Right economy rights	HIS TICARES: management of care and professiona, users training	Values: carity, misericordy, hospitality Respect, justice, person worthy, human life promotion, right to information, spiritual needs, free of believe
spain	Pilares	Integrated Person-Centred care model, evidence based 3 Core concepts: autonomy, integral, individuality Approach: Humanistic Psychology, and Humanized nursing cares		Formal Caregivers received a specific training to achieve the 1 st step and 2 nd step.	Contexts: homes cares, daily facilities, family 1 st step: integrated assessment (home, family, caring needs, caregivers) - 2 nd step: two pathways: a) Caregivers in family: Assessing and training b) Caregivers rest program				

tunis	INNTA-INSP	Promoting and preserving the family framework for elderly people from a holistic perspective	Vulnerable elderly and their families	Multidisciplinary teams made up of medical, paramedical and social staff social worker assistance at home,	spaces for leisure, meetings and social communication to break the isolation of the elderly and to help families . Assistance is provided in cash to facilitate home care of elderly and dependent people. assure vulnerable elderly needs other resources and help are allocated to facilitate the medical and social follow-up at home 1. assistance at home, free care in public hospitals, and domestic help. Homecare financing scheme 2. “Day Clubs” Implementation for the elderly				avoid elderly exclusion and increase elderly well-being

Regional High-Level meeting TEC-MED first draft model,

Date: Monday, 29 June 2020

Started from 9:30 AM to 4:20 PM

Activity 3.1.3b
WP3

This project has received funding from the European Union's ENI CBC MED Programme under Grant Agreement No A_A.3.2_0376

STATEMENT ABOUT THE PROGRAMME:

"The 2014-2020 ENI CBC Mediterranean Sea Basin Programme is a multilateral Cross-Border Cooperation (CBC) initiative funded by the European Neighbourhood Instrument (ENI). The Programme objective is to foster fair, equitable and sustainable economic, social and territorial development, which may advance cross-border integration and valorise participating countries' territories and values. The following 13 countries participate in the programme: Cyprus, Egypt, France, Greece, Israel, Italy, Jordan, Lebanon, Malta, Palestine, Portugal, Spain, and Tunisia. The Managing Authority (MA) is the Autonomous Region of Sardinia (Italy). Official Programme languages are Arabic, English and French. For more information, please visit: www.enicbcmed.eu".

STATEMENT ABOUT THE EU:

"The European Union is made up of 28 Member States who have decided to gradually link together their know-how, resources and destinies. Together, during a period of enlargement of 50 years, they have built a zone of stability, democracy and sustainable development whilst maintaining cultural diversity, tolerance and individual freedoms. The European Union in committed to sharing its achievements and its values with countries and peoples beyond its borders.

Executive summary

The 29th of June of 2020 the Partners of the TEC-MED Project joint with a number of stakeholders (a list of 45 attendees) from 6 countries in the Mediterranean Basin (Spain, Italy, Greece, Egypt, Lebanon and Tunisia) held a meeting with the objective of the present and improve, taking the considerations of the different stakeholders, the TEC-MED model. For this purpose, the preceding formative research that was made during the first year of the implementation of the project was presented followed for the definition of the TEC-MED model. An open discussion was performed with the stakeholders, who previously it was sent the document, to know its strengths, weaknesses and opportunities of improvement. Later, in a Steering Committee they were decided the following steps for finishing the Model.

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List of attendees

Last Name		First Name	Country	Organization	Job Title
1.	**Alonso Trujillo**	Federico	Spain	Assda - Agencia De Servicios Sociales Y Dependencia De Andalucia	Md - Médico Y Técnico De Acción Exterior E I+D+I
2.	**Anastasiou**	Eugenia	Greece	Social Worker	Social Worker
3.	**Alouane**	Leila	Tunisia	Association Alzheimer Tunisie	President
4.	**Arroyo Rodríguez**	Almudena	Spain	Orden Hospitalaria De San Juan De Dios	Jefa De Estudios. Centro Universitario De Enfermería "San Juan De Dios"
5.	**Awad**	Samar	Egypt	Academy Of Scientific Research And Technology	Communication Officer
6.	**Ayman Moustafa**	Sara	Egypt	The American University In Cairo	Research Assistant/Phd Student
7.	**Azar**	Jihan	Egypt	The American University In Cairo	Pharmd
8.	**Badanta**	Bárbara	Spain	University Of Seville	Professor And Researcher
9.	**Barrientos-Trigo**	Sergio	Spain	Universidad De Sevilla	Assistant Professor
10.	**Barroso Fuentes**	Emilia	Spain	Ayuntamiento De Sevilla	Directora General De Acción Social
11.	**Ben Mansour**	Nadia	Tunisia	National Institute Of Health	Associate Professor In Preventive Medicine
12.	**Bourassi**	Amel	Tunisia	Iba	Media Manager
13.	**D'agostino**	Fabio	Italy	Unicamillus	Assistant Professor
14.	**El Ati**	Jalila	Tunisia	National Institute Of Nutrition And Food Technology	Professor, Head Of Department, Responsible Of Research Laboratory
15.	**Elfawal**	Hassan	Egypt	American University In Cairo	Dean, Science & Engineering; Director Institute Of Global Health And Human Ecology
16.	**Ferentinou**	Eleni			
17.	**Fernández García**	Elena	Spain	Universidad De Seville	Nursing Professor
18.	**Frantzi**	Chrysanthi	Greece		
19.	**García**	Silvia	Spain	Universidad de Sevilla	Communication Technician
20.	**Hossam**	Marwa	Egypt	ASRT	
21.	**Hussein**	Shereen	United Kingdom	University Of Kent	Professor Of Health And Care Policy
22.	**Karam**	Georges	Lebanon		
23.	**Korh**	Lea	Lebanon		
24.	**Lima-Serrano**	Marta	Spain	Universidad De Sevilla	Associate Professor
25.	**Maniati**	Aggeliki	Greece	Omnes	Social Worker
26.	**Mirete Valmala**	Carlos	Spain	Fundación Pilares Para La Autonomía Personal	Responsable Del Área De Formación
27.	**Neofytoy**	Agisilia	Greece	Social Worker	Social Worker

28. Ounaissy	Roula	Lebanon	Idraac	Registered Nurse
29. Porcel Gálvez	Ana María	Spain	University of Sevilla	TECMED project coordinator
30. Pura	Diaz Veiga	Spain	Matia Instituto	Researcher
31. Sami	Saly	Egypt	Sekem For Development Foundation	Projects Manager
32. Xenou	Mary	Greece	Public Health And Social Welfare Department Of Western Greece Prefecture	Msc Public Health Inspector , Speech Therapist
33. Beji	Chiraz	Tunisia	National Institute Of Nutrition And Food Technologie	Public Health Doctor
34. Lassoued	Fatma	Tunisia	Ministry Of Health	Family Doctor, Head Of District
35. Liotta	Giuseppe	Italy	Biomedicine And Prevention Dept, University Of Rome "Tor Vergata"	Prof
36. Mac Fadden	Isotta	Spain	Universidad De Sevilla	Researcher
37. Mattoussi	Khaled	Tunisia	The Ministry Of Women, Family, Children, And Senior Citizens	Assistant Director For Senior Citizens
38. Aounallah-Skhiri	Hajer			
39. Domínguez	Isabel	Spain	Universidad De Sevilla	Nurse
40. El-Khamisy	Sherif	United Kingdom	University Of Sheffield	Director Of Research And Innovation
41. Ibrahim	Hany	Egypt	Ain Shams University	Senior Lecturer/Consultant Geriatrician
42. Kammoun	Ines	Tunisia	National Institute Of Nutrition	Doctor
43. Neofytou	Agisilia	Greece	Social Worker	Social Worker
44. Salama	Mohamed	Egypt	Auc,Pp8	
45. Zafiropoulou	Maria	Greece	Merimna /Researchscope	Senior Researcher Healt

Welcoming Note and the meeting opening

The meeting started at 9:30am, Ms. Salma Essaw ,WP3 Leader, gave a welcoming note on behalf of the Project Team Then she started the day by presenting a brief overview of the TEC-MED Project and its structure and funding agency.
Then Ms. Salma Essawi gave a swift instruction on how we should use the control panel of GOTOWEBINAR and encouraged all attendees to post on the social media using the hashtag proposed.
Ms. Salma Essawi Left the floor to the Lead Beneficiary welcome note & Introduction of project new partners PP2 represented by Dr. Fabio D'Agotino (University of Sant Camillus) by Dr. Ana María Porcel**,** the project coordinator. PP6 couldn't attend.
Then Dr Mohamed Salama, PP8 gave a few words on How will the outputs from the workshop feed in the process of preparing the TEC-MED first draft model?

WP3 Overview

Ms. Salma Essawi gave an overview of Work package 3 activities like, 3.1.1 Analysis of the most promising social care initiatives already existing in MED Basin, 3.1.2 Analysis of the current social care practices in the six countries involved in the project and 3.1.3the Gap analysis and TEC-MED intervention framework definition.

Activity of Analysis of the most promising Social Care Initiatives. (LB)

After that Dr. Isotta Mac Fadden, researcher from Spain-LB, has given a detailed overview on the first activity in WP3 "Analysis of the most promising social care initiatives" as results of the activity "3.1.1.a Literature Review & 3.1.1.Case studies", which main objective was To Know what are the most promising social care initiatives for elderly, dependent and/or in risk of social exclusion in European and the Mediterranean Basin countries. More Specifically, to know the characteristics of the social initiatives directed to the target population. And, to determine, when possible, the outcomes/impact of the social care initiative.

For this objective, it was developed a literature review to identify case studies on the best social-care initiatives in the Mediterranean basin countries and the European Union, and social care practices, characteristics and trends in each participating country.
She gave a specific detail about the distribution of work and the methodology for

a) The General literature review (English and native languages of the countries in the project): Scopus and Pubmed literature search
b) The Gray Literature (English and native languages of the countries in the project)
c) The Unified document.

The Selection criteria of the literature were:

Articles that describe, explore, analyze, evaluate specific social care practices and initiatives for elderly (more than 60-5550 years old), dependent in risk of social exclusion, cultural and transcultural, ethic and social-ethic.

Social care initiatives include either implemented programmes or theoretical models which exemplify best practices and innovative aspects of social-care for primary target population. Population target must include dependent, elderly population with chronic illness or lack of family support. The Time frame from 2000 to 2019: from 2000 to 2019. Languages: English, Spanish, French, Italian, Greek, Arabic. And finally, the Design: Qualitative, quantitative, case studies, theoretical.

The models were selected based on the following criteria**:**

- Territorial: National proposals of the countries of the project PPs and European International projects.
- Scientific evidence and expertise: Models that have been implemented with concrete initiatives, duration and with some support for effectiveness and/or evaluation.
- Integrated vision: model with services that contemplate an integrated care and not focused on a specific service. (20 care models)
- The model should include thoritical framework, Main Objectives, management , stakeholders, strengths and weaknesses.

She clarified also that we have used PRISMA 2009 Diagram flow charts for refining data
Through these models many lessoned learned has been noted and the most interesting aspects are for example in the Framework that should **include**

- Holistic and interdisciplinary approach (medical services, psychological, social practical and spiritual support) within the family and home environment; and well-coordinated multidisciplinary care.
- Integrate care: person centered care, clinical, professional, normative, organizational. Systemic integration levels.
- Proactive, empowerment of elderly people, involvement of elderly in health promotion activities, promoting and preserving the family framework for elderly people.
- Multidimensional assessment of bio-psycho-social family.
- Home care model.

- Investments in human capital development.
- Quality of service for the elderly and protecting the caregiver's well-being.

And the most interesting aspects that should be included in the Main Objectives part based on three dimensions (Client, Family/ Professional / Public care)

- Quality of life and prevention.
- Deep knowledge of the legislative and operative (social, health) context.
- Needs of elderly and counteract social isolation in the population age of '80.
- Improvement of established integrated care initiatives (at patients' home, training of professionals, improve public care awareness).
- Improvement of person-centered care for persons with multi-morbidity.
- Innovative approaches in multidisciplinary care.
- Leadership, management and delivery of integrated care.
- Build communities of practice.
- Provide evidence-based advice on matching financing/payment schemes with adequate incentives/Evidence based guidelines.
- Criteria to choose and assess national health promotion programs
- Investigation for success of health promotion and programs criteria that contribute to the success of health.
- Dissemination of the knowledge.
- Build a common set up of European partnership of European Countries.
- Creation of common territory and common development objectives.

Moreover, the Management aspect should include:

- Intervention (Improvement plans for social and health professional, assessment of older people's need, involvement of older people, creation of platform).
- The participatory implementation process (research partners + stakeholders).
- Practical measure (qualitative-quantitative tools).
- Adaptation (set up monitoring procedure): adaptation to local community, capacity building, community network building, improvement plans for social and health professional, assessment of older people's need, involvement of older people, creation of platform.
- Planning (steering group; assess of need and framework; targets and objectives; action plans; indicators of monitoring; Nursing teams self-managed; coaching).
- Progress evaluation (external feed-back of experts; improvement cycle, analyzing of methods, people, cost, etc.; evidence-based, evaluation and dissemination; ej/; Evaluation of social care services in different European countries, transferability effectiveness, coordination, communication and evaluation).

And in the most interesting aspects in the Stakeholders dimension:

- Micromanagement: elderly population with risk of social exclusion, Social professional attending dependent (at a social-enterprise, NGO, etc.)

- Meso-Management: Leadership position of social-enterprise providing social-careservices, leadership position of NGO providing social-care services, leading academic figure studying or working in social-care services.
- Macro management: Leadership position in public administration which provides social-care services (may include policy makers and other stakeholders).

The Strengths in the models has included:

- Multidisciplinary and holistic approach strong support to patients' families.
- Development of national health promotion programmes for the elderly continuing training for the involved professionals list of programmes and contact details improve patient care in the community.
- Strong networking and collaboration with governmental and research centers Campaigns focusing on the positive effects of the initiatives.
- Management improved continuity in nurses/impact on care/longer visits/improved follow-up/improved contact with nurses Integrated care activities maintained or enhanced person centredness, prevention orientation, safety, Efficiency and coordination in health in health and social care.
- Maintaining aged persons within their living environment.
- European network common framework public found and support full and uniform application of the employment contract to increase the welfare of operators; work plan for each micro community.

And the Weaknesses in the models included:

- Lack of implementation of the models with a solid framework.
- Lack of research and data on the implementation effects of models (lack of verifiable data to confirm impact on patient outcome).
- Cultural adaptation/ transferability.
- Territorial inequality.
- Lack of national coordinated and integrated plan.
- Limited specialized care services.
- Lack of information between professionals.
- Unsupportive policy and legislation.
- Insufficient funding and resources.

With this, Dr. Issotta Mac Fadden concluded that the analysis carried out has created the basis for the draft models, showing the most specific aspects of the most promising social care models in Europe and in the Mediterranean area**.**

Analysis of Current Social Care Practices in 6 participating countries (PP7)

The session after was given by **Ms. Lea korh (PP7)** displaying in detail the second activity of WP3 as they were the leaders for the task 3.1.2"Analysis of the current social care practices in the six countries involved in the project"

Ms. Lea Elaborated that Mediterranean countries are showing common trends and needs of social care to elderly dependent populations. To respond to the needs of the countries (Greece, Egypt, Lebanon, Spain, Tunisia) involved in the project, a country assessment of the social practices of each country was initiated and a final report was compiled, that was through Semi-Structured interviews with stakeholders. Each country was in charge of performing at least 3 semi-structured interviews with key stakeholders on the social care process in each country based on a pre-defined checklist and template approved by the lead beneficiary (translated and adapted to local context). Finally, 25 stakeholders participated in the interviews (5 from macro-management profile, 9 from meso-management, 9 from micro-management and 2 representatives from the target population) All interviews were transcribed, analyzed and summarized.

For the semi-structured interviews, questions were divided into different parts:

1. Part I Background Questions.
2. Part II General Questions on Social Care for the Target Group.
3. Part III Specifics of The Country's Social Care Model.
4. Part IV Outcomes Impacts and Evaluation of the Current Social Model.
5. Part V Challenges and Bottlenecks.
6. Part VI Success Factors and Lessons Learned.
7. Part VII Ideal Social Care Model Transcultural, Social-ethical and Gender Perspective.
8. Part VIII Ideal Platform to Implement the Social Care Model.

- **SWOT Analysis of the social care practices in each country**

  Each country, based on the previous literature review and the results from the interviews they carried, conducted a SWOT analysis for the social care in their country where they identified the: Strengths, Weaknesses, Opportunities and Threats

  All the information shared by the partners were compiled in 5 separate country reports for each of the project partners. The initiatives and practices in different countries were mainly responding to the needs of each. Some Examples identified through this report were as follows:

1. Egypt: a longitudinal survey of the aging population with a 10year follow-up to identify the needs of this population.
2. Greece: ACTIVAGE for active aging & FRAILSAFE to assess frailty using the latest technologies.
3. Lebanon: national strategy for old age, national standards for organizations working with older adults, palliative care services, social services (governmental and NGOs.) etc…
4. Spain: model of intervention Decent and Positive Aging (EDP) with a well-developed social security system offering trends for proceeding with better quality of aging through increased activity, engagement and autonomy of elderly population through several steps/initiatives.
5. Tunisia: Social & Health Integration Model and new initiatives and reform, National Program of Education for Adults (PNEA), national volunteering database etc…

Ms. Lea Continued to share the in-depth SWOT analysis and she presented the common aspects between the countries.

- Strength
    1. General trend to a long-term social care system,
    2. Governmental commitment to provide services,
    3. Trends toward active engagement of elderly in community,
    4. Trends toward active aging,
    5. Increased attention paid to healthcare system and unique aging related morbidities.
- Weaknesses
    1. Economic situation and crisis in different countries.
    2. Lack of financial resources and age-friendly infrastructure.
    3. Centralization of services (in most of the countries with government as the sole provider of service) could lead to overwhelming and crashing of system in certain conditions.
    4. Low engagement of private sector and NGOs and collaboration with government.
    5. Shortage in human resources and specialization of human resources in elderly care.
    6. Lack of specialized services in specific conditions related to older adults.
    7. Limited Information and Communication Technology (ICT) services for elderly care in some countries.
    8. Legal and policy issues in relation to older adult's care.
    9. Sociocultural issues related to old age.
- Opportunities
    1. Collaboration and networking between countries and partners.
    2. Funding for improvement of services.
    3. Identification of best practices (active aging initiatives, engaging of elderly into community).
- Threats

1. Any incident/emergency that overwhelm country resources could endanger the system e.g. COVID-19 pandemic.
2. Political instability.
3. Changes in population demography e.g.: increased aging population which could exceeds allocated resources.

- **Suggested Actions**
  1. Using the available networks and infrastructure to facilitate exchange of experiences and collaborate between partner countries.
  2. Translating successful experiences from one country into other countries.
  3. Expanding the networks to include other countries.
  4. Involving more stakeholders.
  5. Informing decision makers to push for improving/issuing regulations that facilitate health & active aging engagement.

- **Characteristics of the platform**

  Partner countries have shared some important features and characteristics that could be characteristics of the new model of care and ICT platform and include:
  1. Ease of use of the platform environment.
  2. The importance of networking with all stakeholders (governmental, non-governmental, medical, academic, social, media, etc…)
  3. Social networking and social integration of older persons within the new model and platform.
  4. Registration process for the dependent older persons in the platform including medical history, clinical record, specific indicators (daily or other), social status, financial status and family status.
  5. Integration of technological solutions within the new model and platform (telecare, telemedicine, monitoring, decision-making platforms for individualized social care, information systems/health history).
  6. Availability of trainings and training modules/materials within the new model and platform to empower caregivers, family members and older persons.
  7. Support of homecare and home caregivers integrated within the new care model
  8. Availability of services, economic empowerment opportunities and social activities related to older persons on the platform for proper referral.
  9. The importance of building a monitoring and evaluation system for the new model of care.

- **Ms. Lea at the end concluded that** the differences in the social care systems among countries are clear on the: Political, Legal, Cultural, Economic Levels. Moreover, some of the common issues among the countries include: Economic situation; Political instability; Staff shortage & distribution of services issues; Global changes in family structures; Culture of Aging.

- A lot of interest was shared on the integration of information and communication technology in the social care of older adults.

- Important stakeholders were identified; Governmental; Non-governmental.; Local Community Groups; Private sector.

Finally, Ms. Lea Mentioned that the gap analysis which will follow will surely provide a clearer understanding of the needed changes and actions in each country and provide a transcultural solution.

After Ms. Lea's intervention, a poll was launched to increase the engagement of the attendees the first poll:

How practical-do you think one model can work for all TEC-MED Countries?

I don't think so 7%

It can work with some individual customization 67%

All TEC-MED countries share same situation and culture 27%

Success of Delphi process & Gap analysis conducted in each country.

After a short break attendee has returned to the meeting slot which was titled" Success of Delphi process & Gap analysis conducted in each country" activity 3.1.3 an overview of the process was given by Ms. Salma Essawi before each partner country presented the outcome of this activity
The Delphi method is a structured process that uses an iterative series (or rounds) of questionnaires to gather information, and rounds are continued until group consensus is reached. This widely used method allows for the inclusion of a large number of individuals across diverse geographic locations and, unlike a face-to-face meeting, avoids the situation where a specific expert may dominate the consensus process.

Ms. Salma Essawi has highlighted the objectives of the Delphi technique and the questions that needs to be answered

- Where are we? (current state)
- Where do we want to go? (Desired state)
- How far are we from our goal? (GAP)
- How do we reach the stated objective? (Initiatives)

Egypt

Then Ms. Salma Essawi Gave the floor to Ms. Saly Sami, SEKEM foundation PP9, the other Egyptian Partner to present the success of the Delphi in Egypt and its outcome

The presentation included an overview on the Participants profiles: Macro management group (3 participants), Meso Management Group (5 participants), Micro management group (9 participants).

- **Ms. Saly has mentioned the Priorities regarding the current state That has** emerged from the responses in the First and second Delphi rounds in relation to the social model of care for the elderly dependent population and / or at risk of social exclusion:
  1. Geriatric health curricula at medical and nursing school.
  2. Geriatric specialized health care.
  3. Aging related Multimorbidity.
  4. Emphasizing role of healthy lifestyle (Diet, exercise, smoking, drug abuse) and life course approach for disability prevention.
  5. Well trained health and care workforce.
  6. Improving Laws and policies regarding elderly care.
  7. Socioeconomic characteristics (Education, occupation, living situation, social network, income) and demographic (Age, gender, geographic location, old age dependency ratio).

- **Priorities regarding the desired state**
  Topics identified in the first and the second Delphi rounds were assessed in the third Delphi round and classified into:
  1. Geriatric specialized health care.
  2. Emphasizing role of healthy lifestyle (Diet, exercise, smoking, drug abuse) and life course approach for disability prevention.
  3. Socioeconomic characteristic.
  4. Well trained health and care workforce.

- **Priorities regarding the GAP**
  Topic 1: few specialized doctors and centres for geriatric health, there are some specialized health care centres, like for Parkinson's or Alzheimer's and there are many general healthcare homes for geriatrics which are not specialized at all.

Topic 2: Healthy lifestyle is not embedded in the society at all. The healthy life style is not linked to disability, Elders rarely follow good life style and many continue smoking even at an old age.

Topic 3: The current situation lacks information regarding socioeconomic anddemographic characteristics.

Topic 4: Informal arrangements are the normal situation. Many families rely on uneducated (usually internally migrant) young female workers to provide care. Private agencies that have been organizing home care are increased in number. However, with no quality assurance measures nor standard training, the risk for older people is increased. There are some limited charitable efforts (mainly religious or international organizations).

The gaps between the 2 states and the steps to close those differences:

Topic 1: Considerable gap. Changing laws, policies, and incentives towards geriatric specialized care. Introducing topics related to aging and providing respect and understanding towards the elderly within school curricula.

Topic 2: Considerable gaps in both the availability and accessibility. Continuous education and raising public awareness in TV programs and internet advertising for the importance of healthy food, exercise and regular medical care to improve the quality of life. Availability of public places that are equipped to help the elderly.

Topic3: The data could be hard to collect. The steps can include cooperating with other organizations, requesting hospitals to collect such data is a must. These data also must be filled by all patients. Well-designed questionnaires could be helpful tools. A national efficient health information system is an utmost priority.
Topic 4: Significant gaps: Offering more specialized curriculums in the universities and providing relevant job positions at different hospitals. None of these points are available in Egypt nor in a prominent way in the MENA region.

Ms. Sally has highlighted the Priorities regarding the most interesting initiatives in Egypt

Takaful and Karama Cash Transfer Program:

1. The Takaful and Karama program is implemented by the Ministry of Social Solidarity and has covered to date 2.26 million households which amounts to approximately 9.4 million individuals, or approximately 10% of Egypt's population.
2. Part of the program aims to protect Egypt's poor elderly citizens above 65 years of age and citizens with severe disabilities and diseases as well as orphans.

3. These vulnerable citizens receive a monthly pension of 450 EGP with no ‘conditions’. The original pension amount was 350 EGP but recently got increased to 450 EGP to enable beneficiaries to cope with price hikes.

Middle East and North Africa Research on Ageing Healthy (MENARAH) Network

1. (MENARAH) Network was established in 2020 to raise awareness and mobilize research related to population ageing in the region.
2. The MENARAH network aims to pave the way for countries within the region to contribute to these regional and international developments. There is a need forbuilding capacity at different levels and across various stakeholders including the academic body; policymakers; the market as well as awareness raising of the public.
3. It is paramount to facilitate further constructive dialogues to establish clear and multi-sectorial plan of action that is able to facilitate an active role of the family, older people, the third sector and the state within a coherent, integral and holistic approach.

Sekem Elderly Care Model:

1. The Elderly care booklet and the software for collecting patient’s history in a specific database are formulated as part of the geriatric care system in Sekem Medical center.

This initiative properties:

1. Focus on people aged 60 years and older, who live in their own homes alone or with a caregiver.
2. Focus on elderly who have multiple health and social care challenges.
3. Focus on elders with disabilities.
4. Address older people’s multiple needs (not only diseases or health problems).
5. Involve professionals from multiple health and social care disciplines working in multidisciplinary teams (e.g. nurses, social workers, pharmacists, dieticians, general practitioners);

Ms. Saly has concluded that

- all general practitioners must have basic knowledge of ageing related health issues and are able to refer to specialist physicians. Geriatric specialized health care must be available at high standard and accessible to all regardless of income of socio-economic status.
- A Full understanding of health ageing among older people and their care givers. More importantly the availability of opportunities to make elders remain active both mentally and physically.
- Models from other countries, such in Turkey, with open gyms targeting older people and public acceptance could be replicated.
- Care agencies (both home and residential care) to be subjected to quality assurance measures.
- Care workers to be registered and subjected to background checks.
- Local authorities to be involved in the process. Better coordination between training institutions and employment agencies and care providers.

Lebanon

Second presentation was by PP7 Ms. Lea El Korh from Lebanon. The Delphi Process in Lebanon was organized in two rounds of online surveys to a total of 16 participants in round 1 and 12 in round 2 (so far). The first round helped in identifying the main themes and priorities and the second allowed the prioritization and validation of information.
Participants were from different backgrounds: Non-Governmental, Governmental, Medical, Paramedical, Private Organizations, Academic, Social. 4 Marco-management, 8 Meso-managemnt, 4 Micro-management

Ms. Lea has highlighted the Priorities regarding the current state in Lebanon

1. Health coverage and health services utilization
2. Financial security
3. Food security and malnutrition
4. Capacity building of staff working in old age
5. Protection of human rights of older adults (through laws and legislations)
6. Social security for old age
7. Emergency Preparedness
8. Empowerment of older people (social/activities, educational/trainings and financial/jobs)
9. Comprehensive and equitable retirement plans and pensions
10. Support of nursing homes (comprehensive services including rehabilitative, preventive, and curative services.)
11. Home-based and family-based support and care
12. Primary care development
13. Social inclusion activities and support
14. Involvement of older adults in their plan of care/ participatory approach
15. Listening to the needs of older adults
16. Empowerment of older women in particular
17. Infrastructure and friendly facilities/cities/transportation for old age
18. Networking and collaboration between stakeholders dealing with older adults (private and public)
19. Old age research development
20. Preventive care development
21. Stigma related to old age and cultural issues

Priorities regarding the desired state in Lebanon

1. Comprehensive health coverage and health services utilization
2. Legislations and laws for protection of human rights of older adults

3. Social security for old age
4. More empowerment of older people (social/activities, educational/trainings and financial/jobs)
5. Comprehensive and equitable retirement plans and pensions
6. Home-based and family-based support and care
7. Listening to the needs of older adults
8. Infrastructure and friendly facilities/cities/transportation for old age
9. Networking and collaboration between stakeholders dealing with older adults (private and public)

Priorities regarding the Gap in Lebanon

1. Infrastructure and City Planning (Elderly friendly)
2. Comprehensive Old Age Care (Health, Financial & Social)
3. Governmental Support and Resource Allocation
4. Research, Data Collection and Development

Ms. Lea has highlighted the Priorities regarding the most interesting initiatives in Lebanon

1. National Strategy for Old Age Care (including basis for old age care, financial & social support, retirement, pension plans and safety nets)
2. Disease Management Programs for Conditions Related to Old Age (Alzheimer's, Dementia, Chronic Diseases, Terminal Illnesses requiring Palliative Care,...)
3. Laws and Regulations Related to Old Age
4. Emergency Plan for Old Age
5. Centralized Unit for Old Age Affairs and Programs
6. Elderly Friendly Cities
7. Governmental Support and Services
8. Community Mobilization and Partnerships with Municipalities
9. Advocacy with Policymakers and Legislators
10. Awareness programs: schools, media, community and professionals
11. Intergenerational Activities and Programs
12. Social and Financial Support Initiatives (work, volunteering opportunities, social activities)
13. Training and Capacity Development of Staff and Professionals working with Elderly Senior Citizens Programs and Benefits

Ms. Lea has concluded that Priorities for Lebanon's older adults are related to the following themes: Health; Financial; Legal; Social; Retirement; Infrastructure; Emergency planning; Training; Education; Networking; Empowerment

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Tunisia

The floor was given to our Tunisian partners PP5 **Dr Jalila El. Ati**, **& Dr. Hajer Aounallah-skhiri** Association Partner.

Currently they developed the first round of the Delphi Panel, the **list of stakeholders participating in the 1st round of Delphi survey** consists in: Macro management (6 different governmental stakeholders); meso-Management (5 Different Civil Society institutes); micro-Management (9 stakeholders include Hospitals, Faculties and private institutes).

The following priorities emerged from the responses in the first round of Delphi survey in relation to the social model of care for the dependent elderly and/or at risk of social exclusion:

- **Regarding the current state**

  1- Economic security issue, in particular for those at risk of exclusion.
  2- Problem of social security.
  3- Geriatric care offer (availability and accessibility to specialized care facilities, qualified health care providers).
  4- Problem of autonomy.
  5- Environmental problem unsuitable for the elderly persons.
  6- Social exclusion (lack of spaces favoring extra-domestic activity).

- **Regarding the desire state**

  1- Develop quality of care offer (develop geriatric services, consultations...)
  2- Develop a geriatrics as a specialty.
  3- Promote primary prevention and control of NCDs (non-communicable disease)
  4- and dependency.
  5- Reinforce social security (home care/adequate needed equipment)
  6- Adapt social security laws for elderly care.
  7- Provide integrated multidimensional care (health, social, ethical) for elderly (comprehensive bio-psycho-socio-economic approach).
  8- Establish a dependency insurance system in the same way as disease or work accident insurance for effective care at best in the family environment or if necessary, in an institution.

- **Regarding the gap**

  The majority of stakeholders recognize the existence of huge GAPs

  1- Only 10 to 15% of the objectives were achieved or far away or need for 10 y for information and training.
  2- Monitoring and evaluation of the existing programmers are shortcomings.
  3- Database on depend elderly persons and/or at risk of exclusion is shortcoming (number, location).

4- Lack of respect of norms within accommodation centers (services, hygiene, ethic) and communication with elderly persons.
5- Insufficiency of legislative framework, weakness of its application and ignorance by elderly persons.
6- Health care and health facilities are not sufficiently adapted to vulnerable elderly people.
7- Nursing staff are not sufficiently trained to assure elderly care.

Dr. Hajer has elaborated on the most interesting initiatives in Tunisia, the most important of them were undergoing until now are:

1. Family placement: This programme is based on giving foster families monthly pension to accommodate dependent or excluded elderly persons.
2. Homecare financing: Family assistance is provided in cash to facilitate home care of elderly and dependent people.
3. Daytime clubs: which offer for elderly persons leisure activities, meetings and social communication.
4. Multi-disciplinary mobile teams: to provide elderly homecare.
5. Institutional Care: for elderly with creation of 12 public and 19 private centers for elderly care.

   Example: Homecare financing:

   Main axis of the national social program of assistance to needy families.

   1- Assistance is provided in cash (200 TND = 65 €) to facilitate homecare for elderly and dependent people.
   2- Other resources and help are allocated to facilitate the medical and social follow-up of elderly people at home and avoid or reduce the hospitalization periods, e.g. aid in-kind, social worker assistance at home, free care in public hospitals, and domestic help.
   3- Multidisciplinary mobile teams made up of medical, paramedical and social staff are working in each governorate to assure vulnerable elderly needs through this program.

   For these initiatives we can highlight the following strengths and weaknesses:

- Strengths:

1. Involvement of the government.
2. Maintaining of aged persons within their living environment.
3. Preserving of family and strengthens the fabric of families and communities.
4. Protection of elderly against exclusion, marginalization and discrimination.

- Weakness:

1- Issue of human resources and financial availability.
2- Depends on both political and civil society willingness.

3- Monitoring and evaluation system is shortcoming.

Greece

Ms. Salma Essawi Thanked Dr. Hajer for her presentation and gave the floor to our Greek Partners PP4 Dr Eleni Ferentinou, Clinical lead psychologist T.E.C. “Merimna”, Patras, Greece

Dr. Eleni, has started by **Delphi process description conducted in Greece** that consisted in two rounds of Online questionnaires, where there were invited participants are still filling the questionnaires in (number of successful participants so far is 15 and 12, and 45 more are invited). The results of the process presented today will keep being adjusted according to the feedback from more replies coming in:

- First round: Identification of main problems and priorities that need to be tackled.
- Second round: Validation of the information and setting priorities on each problem identified on the first round.

Regarding the profiles of the participants, they were Policy makers and regional government bodies (e.g. Regional policy office of Western Greece, 6th Regional Health Office); Localexecutive administration (municipality health offices); Representatives from open health care centers and institutions (e.g. Geriatric and Gerontology Association, University Hospital of Patras); Health care and therapy providers (Public and private sector) (e.g. Therapy clinics, OpenHealth centers, old people’s care homes); andHealth Professionals working in the health sector (e.g. Medical doctors, social workers, psychologists).

- **Priorities regarding current state in Greece**

1- Need of adequate primary Medical care and health coverage.
2- Targeted training for Health professionals.
3- Health care services that are home-based and family-based.
4- Inadequate social benefits.
5- Much needed government intervention for laws and policies for social care.
6- Need for research and assessment (resources and funding) regarding the population group.
7- Minimal social activities for elderly.
8- Much needed support at home and in the family.
9- Empowerment of the elderly and abolishing the stigma related to old age.

- **Priorities regarding desired state in Greece**
  1- Adequate Medical Care, Comprehensible health coverage and services utilization.
  2- Home-based and family-based support and care.
  3- Social integration / care outside (closed) institutions.
  4- Increased state intervention and adequate financial resources / program funding.
  5- Improving the quality of life of the elderly (physical and psychological health).
  6- Covering psycho-emotional needs.
  7- Continuous assessment and recording of needs.
  8- Adequately trained staff through University curricula and CPD programs.
  9- Enhancement of tele-tools and technological familiarity.

- **Priorities regarding the gap in Greece**
  The gap between the current and the desired state in Greece appears to be chaotic. All of the issue presented were deemed of being far from the desired state.
  The need and immediate intervention is apparent for:
- A reform in the Health care system for adequate medical care to vulnerable groups, such as the elderly. (focus on geriatric medicine, specialized geriatrics courses and syllabi that focus on prevention).
- Research and assessment bodies that can gauge the situation and needs at any given time.
- Development of adequate social care policies and measures to abolish social exclusion.
- Psychosocial needs to be met in a number of ways.
- Development of technological tools and training of careers and elderly citizens that would make their everyday life easier.
- Education of the elderly population, Their families and careers on healthy habits and changes in their lives.

Dr. Eleni has identified the Priorities regarding initiatives in Greece

The implementation of the initiatives needed to be taken should begin with the cooperation government bodies and policies. The priorities include:

1- A national strategy for a reform on the elderly care (legislation, better pension schemes and benefit plans, social care models and structures).
2- Introduction of research and assessment bodies to promote a deeper and more organized evaluation of needs.
3- Better cooperation and communication of local policy and executing bodies.
4- Dialogue with health services for the elderly and recommendations to policy makers for new targeted programs, and restructuring/ financing of existing programs.
5- Partnerships with municipalities for the organization of empowerment programs for the community and senior citizens, and ways of including them to social and volunteering events.
6- Better training programs for staff, family and individuals (medical professional trainees, general population).

7- Focus on psycho-social health and introduction of new bodies, such as psychological support teams in and out of already established institutions.
8- Model recommendations for better state intervention and care.
9- Creation / strengthening of structures that will meet the needs of the elderly.
10- Development of tele-tools and familiarization with technology.

Dr. Eleni has Concluded by Summarizing the responses of the participants, three essential goals have been distinguished:

- A well-rounded and holistic assessment of need, so that
- A future implementation of an organized and targeted intervention of the policy bodies is meaningful,
- Towards an adequate social care model that:

1. Supports the elderly sufficiently in the long run.
2. Has a long term goal of abolishing management and
3. Promotes the inclusion of the elderly in the society.

Always with respect to the uniqueness of the population group of the elderly.

Spain

The last presentation in Delphi process and its outcome was for the **Lead beneficiary Spain and it was presented by Dr. Barbara Badanta**

Dr. Barbara started by highlighting the Characteristics of the participants from Civil Society, Public administration, Business, Research and education.Ms. Barbara has described the Delphi rounds conducted in Spain and stated that 54 invitations sent, for the second round 32 and for the third round 26 responses. In the first round, 64% were women, 18,4% from macro-management, 31,6% from meso-management, and 50% from micro-management; 23,7% from civil society, 21,4% from business, 7,9% from public administration, and 47% from research and education.

In the first round, through open-ended questions priorities were identified for the Social Care Practice in the Countries regarding the Principles/ theoretical basis, Legislation and norms, Economic aspects or finances, Target population, including educational aspects, Strategies and tools, settings and/or evaluation. In the second and third round, the list with all the priorities, after content analysis of the first round, were ranging with 7-likert scale ranging from 1 (not important at all) to 7 (extremely important). Except for the GAP dimensions that will assess how near we are from the desire state (the difference between the current state and the desire state) ranking from 1 (not near at all) to 7 (extremely near). Only items not accepted in the second round subject to new review in the third. They were categorized in the following emerging categories: Governance,

Model Characteristics, Professionals and User and Family and according the following aspects: Current state, Desired State, GAP and Initatives.

Interquartile deviations (IQD) was used to assess the degree of consensus of the experts on the priority.

In the second round the priorities, according the experts are shown following table, highlighting the more important for them:

Governance

- **Current state: Territorial differences, Universal coverage problems and guarantee of rights**
- **Desired state: State agreement for attention, Accessibility, Integrated policies - long-term care promotion Universal access and rights coverage, Territorial equity,** User empowerment / participation, Public procurement
- **GAP:** Bureaucracy
- **Initiatives: State agreement and regulations; Universal and integrated coverage; Territorial equity; Public financing; Person-centred long-term care;** User participation; Raising awareness of social determinants and gender; Diagnostic studies; Social protection policies; Socio-educational interventions

Model characteristics

- **Current state: Home support is missing; Absence of medium-long stay centers;** Poor evaluation; Lack of public-private coordination
- **Desired state: Person centred model (biopsychosocial needs); Residential alternatives; Respect for rights and values; Promotion of autonomy; Gradual and flexible care adapted to gravity; Quality assessment; Interdisciplinary team; Make best practices visible; Prevention of abuse;** Home care; Integration of key agents in programs; Attention for medium-long stay; Quality versus business profit
- **GAP:** Professionalization of services
- **Initiatives: Person centred model (biopsychosocial needs); Scientific basis; Home care and professionalization of these services; Reform home care services; Collaborative space design; Residential alternatives; Intermediate care resources; Waiting list coverage; Eliminate bureaucracy; Free-clamping centers;** Primary health care – socialhealth care; Supply-demand adjustment; Portfolio-services protocols; Incorporation of ICTs; Coordination structures (socio-sanitary commissions); Model evaluation; Homogenize initiatives; Ethical considerations; Care cooperative

Professionals

- **Current state: Job insecurity;** Professional stigma; Need of training
- **Desired state: Favorable working conditions, recognition; Adequate professional-user ratio; Socio-sanitary specialization and professionalization;** Research
- **GAP**
- **Initiatives: Interdisciplinary teams**; **Specialization and training; Research; Improve working conditions; Adequate professional-user ratio;** Management specialization; Professional accreditation

User and family

- **Current state:** Greater needs as life expectancy increases; Fragility; Social isolation
- **Desired state: Personalized attention; User / family participation; Promoteautonomy; Caregiver care;** Dependency as part of the life cycle
- **GAP**
- **Initiatives:Empowerment; Inclusion in integrative activities; Self-care promotion**

In the third round new priorities were reached by consensus:

Governance

- **Current state:**
- **Desired state: State Pact for health care; User empowerment / participation; Integrated policies; Active aging and palliative / long-term care promotion; Universal access and rights coverage; Accessibility: Territorial equity**
- **GAP:**
- **Initiatives: State Pact for health care; Universal access and rights coverage; Integrated policies; Territorial equity; Active aging and palliative / long-term care promotion; Social awareness;** State regulations on quality of services; Intergenerational solidarity; Social protection policies; Public financing

Model characteristics

- **Current state:** Lack of support to stay at home; Lack of medium-long stay centers; Public-private coordination
- **Desired state: Home care; Residential alternatives; Respect for rights and values; Active aging; Gradual and flexible care adapted to severity; Socio-health integration; Prevention of abuse;** Home care; Public and private coordination; Leadership of social agents and horizontal management; Companies audit regarding the quality of care; Model based on scientific evidence
- **GAP:**
- **Initiatives: Integrated and person / family focused care; Residential alternatives; Demand coverage waiting list dependency; Prevention of abuse; Reduce bureaucracy; Flexibility of care according to needs and severity; Professionalized home services;** Care quality assessment; Increase in residential places; Home care and local / community care; Primary health care: provision for social health care; Architecture of institutions similar to the user context

Professionals

- **Current state: Job insecurity**
- **Desired state: Improvement of working conditions; Specialization and professionalization; Social recognition; Adequate professional / user ratio**
- **GAP**
- **Initiatives: Adequate professional / usurious ratio;** Training; Research; Professional development

User and family

- **Current state:** Increased needs due to longer life expectancy; Social isolation

- **Desired state: Personalized attention**; **Promote autonomy**; **Family participation in decision-making; Caregiver care; Dependency as part of the life cycle**
- **GAP**
- **Initiatives: User / family empowerment**; **Development of integrative activities**; Self-care promotion

Dr. Barbara has concluded that According to experts a social care model should be based on the following:

Governance:

- State agreement
- Universal access and rights coverage
- Integrated policies
- Territorial equity
- Public financing
- Long-term care promotion
- User participation
- Social awareness

Model Characteristics

- Person centred model
- Active aging
- Scientific basis
- Reform home care services
- Professionalized home services
- Collaborative space design
- Residential alternatives
- Intermediate care resources
- Waiting list coverage
- Respect for rights and values and prevention of abuse
- Reduce bureaucracy
- Flexibility of care

- Quality assessment
- Make best practices visible
- Socio-health integration

Professionals

- Improve working conditions and social recognition
- Interdisciplinary teams
- Adequate professional-user ratio
- Specialization and training
- Research

User and Family

- Personalized attention
- Self-care promotion/ Autonomy
- Inclusion in integrative activities
- User / family empowerment and participation in decision-making
- Caregiver care
- Dependency as part of the life cycle

4

After Thanking Dr. Barbara on her presentation, Salma Essawi has launched the second poll in the meeting: What is your specialization field?

Social sciences 31%
Medical Care 54%
Politics 0%
Economics 0%
Other 15%

Present the TEC-MED first Draft model (LB)

It was then the time for Dr. Marta Lima Serrano from the Leader Beneficiary University of Seville, Spain **to present the theoretical TEC-MED Draft model. Dr. Marta has started her presentation by introducing the team that has worked on the model Dr. Ana Mª Porcel, Dr. Marta Lima, Dr. Barbara Badanta, Dr. Isotta Fadden, D. Silvia Silva, Dra- Elena Fernández, Dra. Regina Allande Sergio Barrientos .**

After that she gave an Introduction on the elderly population worldwide, 200 million in the world (12% of the world population) have reached or surpassed the health life expectancy (60 years). These figures will increase in the next three decades, where older than 60 years old will duplicate and octogenarians will quadruple. (WHO, 2020).
The higher life expectancy is as result of public health policies and of the socioeconomic development. However, elderly population is not always with good quality of life, showing fragility and dependence. (Brañas et al., 2018)
Over 50 million persons in Europe have more than one chronic disease, and over 100 million are at risk of poverty or social exclusion, which suppose an increase in health care spending to a 20% of country budget. (Eurostat Statistics Explained, 2018)
The countries of southern Europe, support to some of the oldest civilizations in the world, in addition to sharing cultural ties.
The current health crisis has highlighted the need to work towards a model that increases the capacities and competences of care providers related to elderly and vulnerability that can be incorporated into Social and Health Policies.

The TECMED research project of the ENI CBC 2014-2020 call addresses these challenges, developing a model of cross- cultural, ethical and social care for the dependent population in the Mediterranean basin. With an approach based on justice, privacy, confidentiality, gender, universal accessibility, active community participation and the values of the welfare state and governance.

Marta gave a deep overview on the **Scope of the document to** know which are the most promising social assistance initiatives for older people who depend on the risk of social exclusion in the countries of the European and Mediterranean basin through an extensive literature review. To recognize social care practices in each of the countries involved in the Project as well as their strengths, weaknesses, opportunities and threads through semi-structured interviews and SWOT analysis in the participant countries participants in the TEC-MED project. To analyze the Gap in the participant countries in the TEC-MED project through a Delphi panel.

With this all formative research together with a meeting with international experts from the Mediterranean Basis will be refined the Definition of the TEC-MED Intervention Framework to propose the TECMED Model. An Intervention Framework is the pillars that guide the construction of a model. A model is the way of understanding or interpreting these pillars or conceptual bases. Therefore, in this document, the pillars are first presented (Theoretical framework or metaparadigm) and then the pillars are interpreted with the TECMED vision (TECMED Model) to respond to the model's mission.

She has stated that the **Vision of the draft model is the** *Worthy care for the elderly*.

The **Mission of the model is to** *Serve as a catalyst to promote quality services based on a socio-ethical and cross-cultural model for the elderly in the Mediterranean basin*.

In the definition of the model we can difference the theoretical framework or metaparadigm that represents the distinctive domain with a unique perspective distinctive of others. Subsequently, the less abstract level, and more specific and explicit are the conceptual models (Benner et al., 2003).

In the TEC-MED Model the Theoretical Framework includes six dimensions (fig 1):

Figure 1. TEC-MED Model Theoretical Framework

Then she gave an in-depth overview on the TEC-MED model sections which include

- Subject of Care; it is highlighted that person is the center of care.
- Health and social care providers; with Inter-professional perspective
- Care environment service delivery; where the Physical and socio-cultural coordinated and integrated
- Governance; Steering and rulemaking must be focused in the person and integrated care

- Financing; Funding priorities at the political level and the government level
- Technology; Telemedicine, Electronic health records and other health and social platforms

Dr. Marta Lima has introduced the Theoretical framework levels TECMED model (macro, meso, micro) and transversal concepts of the model.

Regarding the model, she highlighted that the model should be Person centered integrated care focused. And she showed the key transversal concepts in more details as follows (fig 2);

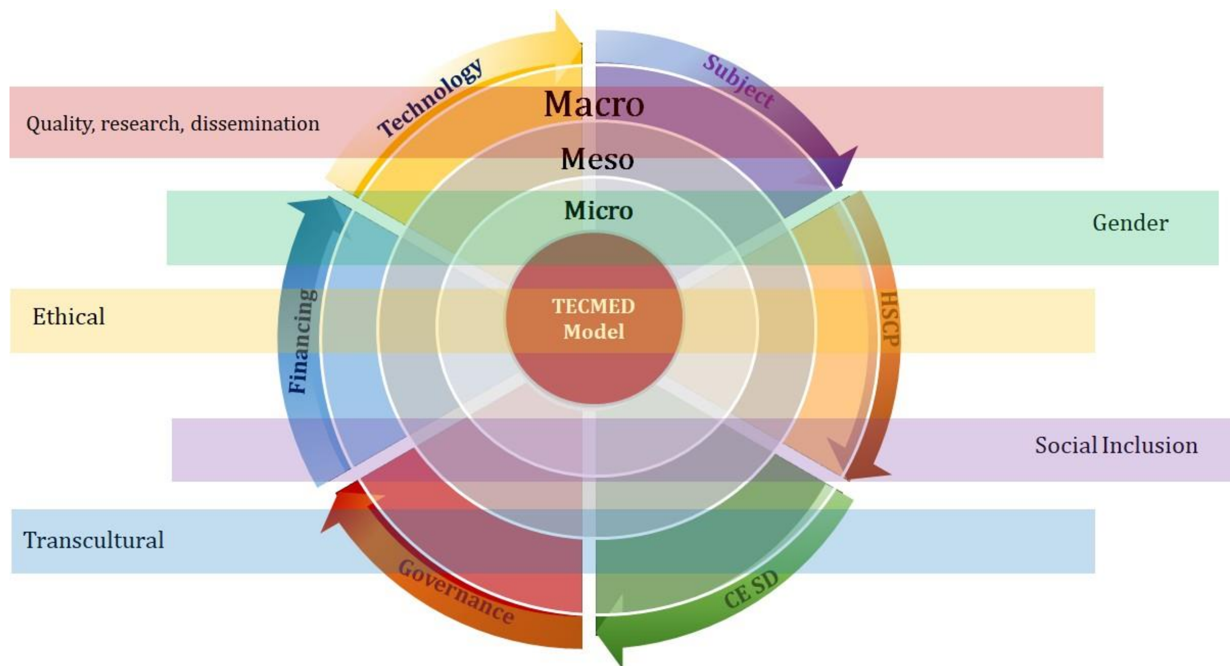

Figure 2 Theoretical Framework Level (macro, meso, micro) and transversal concepts of the model

- **Quality, Research, Dissemination.**
  Quality: Should be linked to aspects such as respectful human rights and dignity, person-centered, preventive and rehabilitative, available, accessible, affordable, comprehensive, taking into account the transparency, gender and the culture.
  Research-supported care aims to create new knowledge and /or the use of existing knowledge/ good practices in a new and creative way so as to generate new concepts, methodologies and understandings, all of which contribute to increased quality.

  Dissemination means sharing research/good practices results with potential users - peers in the research field, industry, other commercial players and policymakers and transfer.
- **Gender.**
  Gender refers to the roles, behavior's, activities, attributes and opportunities that any society considers appropriate for girls and boys, and women and men. Gender interacts with, but is

different from, the binary categories of biological sex.

Promoting equal economic independence for women and men, closing the gender pay gap, advancing gender balance in decision making, ending gender-based violence and promoting gender equality beyond the EU.

- **Ethical**
  Autonomy as a right of a person to determine his or her own destiny; the beneficence as a way of doing good (not only just the client but also the family and the social and healthcare professionals); the justice as a way of seeking the sharing of benefits and burdens based on fairness and equality. When any of these ethical principles are overlooked, a person may be at risk for neglect or abuse.

  In addition, others bioethical principles are related with privacy and confidentiality and empowerment. (American Society of Aging, n.d; Rodriguez González, 2016)

- **Social inclusion**
  The capacity of a society to ensure the welfare of all its members, minimising disparities and avoiding polarization. (European Committee for Social Cohesion, 2004).

  Social inclusion is about having access to opportunities, options and choices in life and having the resources and appropriate support as well as the personal capacity, self-confidence and individual resilience to make the most of them.

  Older persons should be treated fairly and with dignity, regardless of disability or other status, and should be valued independently of their economic contribution (United Nations, 2002).

- **Transcultural**
  The transculturality is defined as the phenomena that result when groups of people, who have different cultures, make continuous first-hand contact, with consequent changes in the patterns of the original culture of one of the groups or both (Marrero, 2013). Transculturality does not necessarily imply a conflict but consists of a phenomenon of cultural enrichment.

  Sensitive Health Care Model for explaining the linkage between the provision of patient-centered, culturally sensitive health care, and the health behaviors and outcomes of patients who experience such care (Tucker et al., 2011). The delivery of care that is cultural appropriate prevents unnecessary conflicts between clients and caregivers from varied cultural backgrounds.

- **TECMED Model I. Subject of care**

Dependency: permanent status, derived from age, illness or disability, and linked to the lack or loss of physical, mental, intellectual or sensory autonomy. (Boletín Oficial del Estado, 2006).

Social exclusion: can be understood as a number of social mechanisms leading to threats to the integrity and cohesion of the collectivity and challenges to the common identity of their members. (Vykopalová,2016).

Elderly: Ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time. These changes are neither linear nor consistent.
While some 70-year-olds enjoy extremely good health and functioning, other 70-year-olds are frail and require significant help from others (WHO, 2020).

- **TECMED Model: Health and social care providers (HSCP). 12:27 PM**
    - Multi and interdisciplinary teams including health and social professional, formal and family carers .
    - Clarity about each other’s expertise, roles and tasks, from a transdisciplinary horizontal perspective (equity).
    - Workforce policy and planning focused in capacity building and training must be considered. The workers must be involved in the designing and evaluation of this policies.
    - The health and social workforce performance should be defined by: coverage, productivity, technical quality, service quality.
    - Financing and incentive for investing in workforce it is needed to assure the enough human resources.

- **TECMED Model: Care environment and service delivery (CESD). 12:28 PM**
    - Integrated social and health care responds to person needs and preferences, holistic perspective, a person-centred vision.
    - Supportive environment with enough resources, material and human focusing in housing alternatives
    - Maintain the people's autonomy, promote positive active healthy ageing (self-management/personal skills).
    - Proactive health promotion and prevention, fight with the abuse, or neglect.
    - Different services and institutions they must be perfectly coordinated, involving the community resources assuring the continuity of care.
    - Periodical evaluation must be developed with measurement and analysis and results based in performance and outcomes indicators, financial performance and feedback (bottom-up).
    - Principles such as safety, efficiency, availability, accessibility, continuity, affordability, transparency and sustainability must be taken into account.

- **TECMED Model IV. Governance**

- Users and family members must participate in the design of policies to ensure that they truly meet the real needs.
- Raising awareness of social determinants and gender.
- Policies must have continuity over time, beyond political changes at the local or national level.
- The management and availability of services and resources should be adequate to the needs of the population according to territoriality.
- It is recommended that policies based on active and positive aging (WHO, 2002) and long-term care predominate.
- Governance should include planning and management of needs assessment studies and quality assessment systems for policies and the care provided.

- **TECMED Model V. Financing**
  - To promote financing public, universal and transparency.
  - Transparent entrepreneurship concentrates on innovation, leadership responsibilities for performance achievement and joint financial agreements.
  - Bet on the inclusion of a social and solidarity economy (Askunze, 2013), sustainable human development, the feminist economy and the ecological economy, betting on "another fairer economy".
  - Some initiatives of the implementation are care cooperatives, social immersion companies, social currencies, time banks, barter markets, etc.

- **TECMED Model VI. Technology**
  - Digital social interventions should be accessible at a minimum via mobile devices
  - To support: population care, training, recording of the information, the alert notifications, communication and coordination, and for evaluating the quality of the care provided, and the policies (WHO, 2019).
  - Use of artificial intelligence and robotics to help older people manage and create a better and safer quality of life, allowing the management of activities in their environment and data management.
  - Technological support for monitoring and sustainable assistance (sensors and devices that allow the gas to be closed, lights to be turned on or off, or air conditioning to be managed).

In summary the TEC-MED model is a person-centred integrated care model which consists in 6 dimensions of the theoretical framework, divided in three levels of managements and five transversal concepts.

Interactive “Group” Discussions

After 20 min break we started the “Interaction Group Discussion” **12:47 pm**
Ms. Salma Essawi has started the session by describing some ground rules for participants, and how to use the mic and raise their hands or even use the questions tab. Then she gave the floor to Dr Mohamed Salama the moderator of the session Dr Mohamed Salama Said : we need to Listen to experts to learn more and to know their feedback.
First intervention was from **Dr Shereen Hussein:** The founder of Minara initiative in Egypt reply: it is very interesting being part of this project and attended to see what you doing , we all know that southern European countries has strong social care model of elderly and that’s links very well to our country to communicate. It was also interesting to see the communality between countries and maybe you need to hear more the voices of elderly themselves not only the higher level. To make sure we integrate that in our model. We aspire to have long term supporting to elders the reality of day to day practical, Availability of support to aging, Participation opportunity, to communicate more with old people themselves, We need to work more for care elders. We need highly level of integration. Dr Mohamed said that Dr Shereen involved in social care and care for elderly for long time in Middle East as well as in UK and in Europe. **Ms. Shereen Hussien**: to Draw well on what the kind common that element connect well and works well. She takes about problem of implementation and different culture of each country. And Look in different sections in our region and the presentation when they share the players and the integration of governmental and the element to connect.
Dr Federico Alonso: Director of agency Social services and Andalusia government, continues his intervention thanking to participate in this meeting, he also wants to highlight the importance of this activity specially after COVID 19 as In Spain more than 28% people retired many of this people don’t have a care. The right of confidentiality and participate in decision-making process. Need high quality of care and he identified by ethical right. The digitate evaluation to monitoring in this process. More important to be autonomy respect.
Dr. Almudena Arroyo reply from Spain : In Spain there is no model for care elderly, depend on the Spain institution care but not from the people. Need autonomy and dependency. Covering the development of the person. Integrated approach for the person. The approach which we Need dynamic interventional model insert integrating to the community. Charity person in this area. The participate patient of people in organization of cooperation services. Economy dependency. Training to care elder. Dynamic flexible model to use. Particle model is very important. The weakness of the model related to culture of each country. And use the technology is very important, support of Public institution of social care
Dr. Jalila El Ati from Tunisia commented: we have some comments and some questions about this draft model:

First comment: the theoretical level the model and respect of the issue but the model doesn't highlight the specification of each country in the model care.
Second comment: the disability ruler for the elder we need to take to count in the model and in the media.
We need to highlight for implementation and sustainability of function model.
Within discuss with the team we didn't find the practical aspects model.
Dr Nadia Mansour from Tunisia commented, The model is comprehensive but she needed to take about implementation specially in our countries in economic crisis that is why she highlighted the prevision and promoting how the life styles more general population that will decrease problem of care and social intervention.
Ms. Pura Díaz-Veiga from Matia Instituto: First of all, she thanked to those responsible for this project for the opportunity to have participated. she believes that the TECMED Model that you propose includes the main keys that must be integrated into care for the elderly. It also seems to me that it can be very relevant in the current Spanish context. She does some suggestions for improvements: The first is related with ageism. I think that the TECMED model must consider the importance of beliefs and stereotypes associated with age at all levels. Ageism is present in our societies and in the current crisis it has been present in many decisions that have discriminated old people and have reinforced stereotypes based on a homogeneous and deficient characterization of old age. From this point of view, the TECMODEL should to include specific measures to promote a social image of aging, adjusted to the diversity of elderly people. My second suggestion is to promote the participation of the old people to contrast the lasts version of TECMED Model. I think it's important to include them in a proposal like this that wants to be inclusive and old people-centered. In the other hand, the profesional training is a an important topic to be considered in the development of Model. Most of today's professionals come from a healthcare model and have to acquire new skills with person-centered care
The next intervention comes from **Vicente Pérez Cano** and **Luján Japón Belmonte.** In Spain there is no style or model of care for the elderly. What we do is not based on the needs of the people but on those of the institutions, professionals, unions or the business, and is conditioned by certain paternalistic and overprotective nuances. These lines are a very brief reflection of a person-centered, more humane, and more efficient model that we have already experienced. Its keys are the following:

- From autonomy to dependency.
- Favoring the development of the person.
- Each person in the environment where he lives.
- With an interdisciplinary, integral and integrating approach to the person.
- With varied answers, adapted to the changes of each person.
- Counting on the participation of the elderly.

The approach we propose is a dynamic model of intervention, inserted and integrated in the community, carried out by a team of professionals who, with an interdisciplinary approach,

responds to the needs of all the elderly in their environment, from before access retirement until the end of life.
People want to age in our environment and we have the right to choose where and how to age. This need can be met since in almost all towns and neighborhoods there are varied resources for the elderly: leisure and cultural resources, day centers, home supports, residences ... among other resources.
The key is that the needs are analyzed, in each town or neighborhood, as a team, and as a team the type of intervention most appropriate to each evolutionary moment of each person is determined. This way of working guarantees something very humanizing because the team knows each elderly person in their area and is dosing resources as needs evolve with agile, flexible and effective responses at all times. The participation of people in the organization and operation of services is fundamental in this model.
The different resources must be articulated, from autonomy to dependency, as part of an integrated whole so that people use a leisure, training or care center both at home and in Day Stay Units or residence. In addition, this is a dynamic and flexible model that allows rational and variable use according to the person's condition.
Ms. Emilia Barroso focus in the preventive perspective, promoting health ageing. Respecting of independency is very important aspect, Need to interconnection between 3 levels Marc – Meso-Micro levels because every other models concern only in micro level only.
Dr Mohamed Salama reply : We will start with the pilot and questionnaire in the first to transfer from theoretical model to practical.
Ms. Fatma Lassoued: Question: she join professor El- Ati, in the idea of disability between countries in Tunsia for example need for north Tunsia the same for South Tunisa and in this model she didn’t find the specific for the districts for cities.
Ms. Hajer Aounallah-Skhiri from Tunisa: We need to take into account the disparities according to area and to countries and economic and geographic and accessibility to have care to social care and we need to work in these aspects, and we need to implement, and when we do the pilot we need to take care about this aspects.
Dr George Karam from Lebanon: Move from theoretical step to be practical and he don’t know what are we going because it is still very theoretical and we need to be more practical, and each country have specificity, and needs to fast start to be practical not to be theoretical.
Ms. Salma Essawi Said : that Dr. **Marta Lima** first draft model proposal is an overall theoretical framework , but actually after our today’s meeting we have more the outcome of each country identified priorities , and the gap analysis which give us a clearer vision to proceed with the creation of the practical pragmatic TEC-MED model .**Dr. Marta Lima** agrees, more important that we found formal research and analysis, so in the next step is how to implement principle in the different country.
Ms. Salma Essawi: we need the partners to tell what the next step and how to put every thing on the table to will identify and to organize our work together, to reach the TEC-MED model.

Mr. Carlos Mirete considers that the model covers a wide and complete view of most areas involved in improving care. Key subjects are also well identified.The subject of care, as the centre of the model, is not only well identified but there is a chance of strength this message Is aimed through this holistic approach to all critical agents involved in care and in changing the content of how we approach care.
Regarding the weaknesses, the scope when we talk about the subject of the model. We should integrate rights as the way of measure every care approach. We should enforce the view of rights and the enjoyment of them considering autonomy and dignity and its relation to a life deserved to be lived in all actions we should take from now Macro-meso-micro levels are not consistent through areas. Although i acknowledge the differences among each of them, we should make a more consistent approach in every field. Cultural values should be better address, not only from the government side, but changing them.
How could it be improved? A focus on rights, cultural views and mores, and how the latter determines the former should have bigger presence Include "transdisciplinary" as a complementary approach to find new solutions
What are the main suggestions regarding the strategies for the implementation of the Tec-med model? Considering cultural change starting from behavioral changes in all of the 6 dimensions from ground levels to social levels (action at micro for changes in meso and macro) A focus in rights cultural view and find new solutions.

Sometime was given to Barbara and Lea to generate and conclude participants' comments, Ms. Salma Essawi has launched two polls

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Now, how much do you know about TEC-MED?
Nothing 0%
I think I know some data 46%
I think I know the whole story 54%

How did you know about TEC-MED? **13:46 PM**
Our emails 6%
Social Media 0%
Press release 4%
Colleagues 90%

Interactive Discussion Conclusion

Dra. Barbara has concluded and shared some general idea for all questions. They are paternalistic models, focused on the needs of institutions, professionals, or business.
The characteristics of a good model of social care must consider the rights of the person, take into account the person in a unique way, with their environment, family, dignity and culture. Also the model must promote autonomy, active aging, the person should remain in her environment and home if the person wishes, even to die at home, the team of professionals must be interdisciplinary. Social and health care must be humanized, be more integrated to provide quality care, respecting the dignity of the person and the right to receive information. The needs must be covered taking into account the differences according to territories, neighborhoods and others.
It is important to integrate the views of older people, informal caregivers and technical professionals in the development of the final model. In some countries with economic and political problems, it is very important to detail how the actual implementation of the model will be possible. Investing in social capital is crucial.
We must clarify how we are going to overcome socioeconomic disparities, accessibility barriers, etc. For example, from Tunisia and Lebanon, they propose to include and discuss more practical aspects of the model.
Some participants propose a better connection or coordination between the macro, meso and micro levels.

Ms. Lea has added : few points regarding the improvement : Participant gave important feedback during common elements and working well in different countries and adapting to the local context so we can start by a pilot and important interventions at different levels so as not have too many points to implement and to be not able to deliver more, and the importance of having practical steps to move forward and to take in the account the dynamic in different levels specially in 6 dimensional in the theoretical model .

Break from 2:00 PM to 3:30 PM

Steering Committee. From 3:30 PM to 4:17

Participants: LB, PP5, PP7, PP8 and PP9.

Dr. Sergio gave a brief introduction of the Meeting of what is expected next, that must be the inclusion of new proposal to improve the model and to do it more operative. This should be included the following aspects:

- Attention to the needs of the population: physical, psychological and social needs, non-marginalization, promotion the inclusion
- To promote legislation and laws for the protection of human rights of older adults
- To promote the geriatric specialised health care available at a high standard and accessible to all regardless of income or socioeconomic status
- To promote healthy ageing
- To improve care attention for elderly people with centres subjected to quality assurance measures and the improvement of training of the health and social care providers.

Other aspects that we want to highlight are:

- Coverage
- Financial matters
- Incorporation of technologies
- Coordination and cooperation
- Research
- etc.

- Importance of the incorporate of experts in different points of our project development. Opinions have been very interesting and they have incorporated some points of view such as:

  - There is no unified model of care for the elderly.
  - The characteristics of a good model of social care must consider the rights of the person, take into account the person in a unique way, with their environment, family, dignity and culture.
  - It is important to integrate the views of older people, informal caregivers and technical professionals in the development of the final model.
  - Better connection or coordination between the macro, meso and micro levels.

He asked Salma Essawi as the work package leader to start preparing the technical model gathering information from all activities that has been done so far. Salma Essawi as a leader of our activities in this work package coordinate the activity too , We share all suggestions by email later which consists in to divided the different dimensions by countries in order

they can be improved and operationalized; later we will have a new Steering Committee where the Model will be reviewed again by all the partners to prepare the final version of the TEC-MED Model.

Then an open discussion was allowed to all partners to Discuss the step forward in order to create the TEC-MED model. Marta has talked about finalizing our target and finish Delphi rounds as soon as possible. Tunisian Team suggest finishing these tasks within 2 weeks for the sake of including high profiles stakeholders. Finally, one week was given to finish this task. And we must have action plan and work in parallel to finish the Model as all other activities of the project based on it.

A group photo was taken in the end.

Thank you

Salma Essawi

GROUP Photo

Annex1 Meeting Agenda

TEC- Med Social-care Cross-Cultural Model (TEC-MED Intervention Framework)

Date: Monday 29th June 2020 – 9.00am to 14:15 - **All times are EET (GMT+2) (for all participants)**

9.00 to 16.30 (for Project Steering Committee)

Programme

Plenary Session (Morning)
Link to the Meeting Room: https://attendee.gotowebinar.com/register/8233018131759505935

9.30am: Welcome & Ground Rules
9.40am: Plenary Session – Setting the Scene

- Introduction: How will the outputs from the workshop feed in the process of preparing the TEC-MED first draft model (PP8)
- WP3: Overview (PP8)

10.00 -10.20Activity of Analysis of the most promising Social Care Initiatives. (LB)
10.20-10.40 Analysis of Current Social Care Practices in 6 participating countries (PP7)

10.40-11.00 Break

11.00-12:10 Success of Delphi process & Gap analysis conducted in each country (PP8).

Delphi GAP introduction (PP8): Introduction+ methodology

- Egypt (PP9)
- Lebanon (PP7)
- Tunisia (PP5)
- Greece (PP4)
- Spain (LB)

12:10-12:30 Present the TEC-MED first Draft model (LB)

12.20-12.45 Break & Reflection
12.45-14.00 Interactive "Group" Discussions

(Dr. Mohamed Salama, Moderator /Rapporteur, Barbara)

- What are the strengths/ weaknesses of the TEC-MED model?
- How could it be improved?
- What are the main suggestions regarding the strategies for the implementation of the TEC-MED model?

14.00-14.15 Wrap-Up, (PP7)
End of Meeting

14.15-16.30(Closed meeting) Steering Committee

14.15-15.30 Lunch Break and Reflection

15.30- 16.30 Steering Committee for conclusion about the Creation of the TEC-MED Model & The Next Steps.

Link to the Meeting Room: https://attendee.gotowebinar.com/register/8233018131759505935

LEAD BENEFICIARY: PROJECT PARTNERS:

PP=Participant partnerLB=Lead beneficiary