Middle East Journal of Nursing

March / April 2017
VOLUME 11 ISSUE 1

ISSN 1834-8742

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FROM THE EDITOR

Abdulrazak Abyad
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(Chief Editor)

This is the first issue this year and has three landmark papers. The first paper from Jordan deals with physical abuse among Syrian refugee women in Jordan. This study aimed to investigate the prevalence of physical abuse and its association with some socio-demographic variables among Syrian refugee women in Jordan. A total of 182 Syrian refugee women visited the Maternal and Child Health Centers (MCHC) in Mafraq district had been participated in the current study during March 1, 2014 and June 1, 2014. The Arabic version of the NorVold Domestic Abuse Questionnaire (NORAQ) was used to collect data from the study participants. The results revealed that more than third of the participants (57, 31.3%) experienced physical abuse (before and after refuge). Twenty seven participants (14.8%) reported being physically abused during the last year. Husbands were the arbitrators in 38.6% of the physical abuse acts reported by the participants, followed by fathers (14%) and brothers (10%). The bivariate analysis revealed that educated women, older women, come from small size families (<6 members), and those who got married at or after 21 years old were less likely to report physical abuse. The regression model analysis showed that educational level of the physically abused women is the strongest contributing factor to predict their psychological suffering scale (Beta= -1.7, $p < 0.05$) followed by.marital status and household income (Beta=-1.3, and 0.94 $p < 0.05$) respectively. The authors concluded that the current study will pave the road to fill the gap in the literature in regard to physical abuse prevalence and the associated factors among Syrian refugee women in Jordan. However, further research will be needed to address this important issue.

A paper from Australia looked at the issue of Practices Nurses. The author stressed that Practice Nurses are a relatively new addition to general practice/family medicine and an innovation that is being implemented in most countries globally. They offer cost and time savings to clinics and sole general practices, through taking on some roles of general practitioners/family doctors, thus relieving them for more focused medical duties. Additionally they take on duties that benefit quality care of patients and duties that may benefit the practice financially (e.g. health promotion and monitoring, patient recall, disease prevention, office management, infection control, immunisation) and reduce incidence of adverse events. Practice Nurses have also been found to be a cost saving factor in national Health Budgets. Such Practice Nurses however need appropriate training and there are a range of qualifications for modern day practice nurses , some more general and some specific.

The third paper is part of a series of papers from Lebanon on The Future Home Health Care in the Middle East Region. The first part deal with International Perspective. The author stressed that Home health care has gained widespread acceptance recently in the developed and developing countries. This move is affected by the aging of the population, the improvement in medical technologies and the effort to improve quality and reduce cost. The home services vary from nursing care to the concept of hospital at home. The first part of this paper deals with a general view of home health care. It presents the American and Chinese models.

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PHYSICAL ABUSE AMONG SYRIAN REFUGEE WOMEN IN JORDAN

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Abstract

Background: Physical abuse of women is the most common form of female abuse all over the world.

Objective: The current study aimed to investigate the prevalence of physical abuse and its association with some socio-demographic variables among Syrian refugee women in Jordan.

Methods: 182 Syrian refugee women visited the Maternal and Child Health Centers (MCHC) in Mafraq district and participated in the current study during March 1, 2014 and June 1, 2014. The Arabic version of the NorVold Domestic Abuse Questionnaire (NORAQ) was used to collect data from the study participants.

Results: The study findings revealed that about one third of the participants (57, 31.3%) experienced physical abuse (before and after refuge). Twenty seven participants (14.8%) reported being physically abused during the last year. Husbands were the perpetrators in 38.6% of the physical abuse acts reported by the participants, followed by fathers (14%) and brothers (10%). The bivariate analysis revealed that educated women, older women, those who come from small size families (<6 members), and those who got married at or after 21 years of age were less likely to report physical abuse. The regression model analysis showed that educational level of the physically abused women is the strongest contributing factor to predict their psychological suffering scale (Beta= -1.7, $p < 0.05$) followed by marital status and household income (Beta= -1.3, and 0.94 $p < 0.05$) respectively.

Conclusion: The current study will pave the way to fill the gap in the literature in regard to physical abuse prevalence and the associated factors among Syrian refugee women in Jordan. However, further research will be needed to address this important issue.

Key words: Physical abuse, Refugee, Syrian women, Jordan

Background

Physical abuse against women is defined by the United Nations as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

Domestic violence is a worldwide public health concern. However, high vulnerability of women in developing countries increases the risk of being battered by husbands and / or a family member (1). Social and cultural norms in the Arabic societies allow men to discipline women by physical acts such as beating (2). In such patriarchal societies, the political and legal context may contribute to the increase in violence against women (3). Also, legislation and traditional practices do not criminalize violence against women, but justify it through religion, culture, and often the health authorities and security or legal authorities, consider violence against women as a family interest and must not be shared with the outsiders. Domestic violence prevalence against immigrant or refugee women in the host countries might not exceed the rates in the original countries. However, the vulnerability for refugee women is expected to escalate, because they lost their resources such as their families and support systems (4).

Violence against women in Arab world has not been sufficiently studied (5). High prevalence of physical abuse against women has been reported by few studies conducted in the Mediterranean and North Africa region. One of such studies that collected data on physical violence from 262 women living in Palestinian refugee camps in Jordan found that 44.7% of the women participants reported lifetime beating (3). Similarly, the findings of a study conducted in Saudi Arabia showed that 25.7% of the women in Medina district reported being physically abused by their husbands (6).

Some research suggested an association between poor socio-demographic conditions and physical abuse and wife beating. For example, the results of a survey carried out in 2005 on the prevalence of wife beating in Egypt revealed that women who live in urban areas were less likely to be beaten by husband than that of those who live in rural areas, and women whose first marriage was at 30 years old and more were at higher risk for wife beating (7). Women's age and educational level were also found to have an inverse association with physical violence against women (8, 9). Other research linked household income with physical wife abuse (10, 8)

In previous research physical abuse has been reported to coexist with emotional abuse (11, 5, 12, 2, and 13). In addition women who are physically abused by their husbands were often abused by another person such as a family member (11).

Reporting physical abuse to a health professional and/ or talking about it to a friend or a family member is the first step to break the cycle of the domestic violence. Yet, many women hesitate to discuss their status with anyone because they fear to lose their husbands, housing and/or children (Gender-Based Violence Area of Responsibility (GBV AoR), DRAFT - Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, 2014) especially if they are financially dependent on them. Other reason might be the socio-cultural norms in the Arab conservative societies that stigmatize the divorced or separated woman as a bad person. Thus, low reporting of physical abuse is expected, particularly, among the disadvantaged communities such as refugees and immigrants in developing countries where only 7% of gender based violence is officially reported cases.

Psychological consequences of women abuse might be similar or even more serious than that of physical consequences; depression is one of the most frequently reported psychological consequences of the physical abuse against women (14, 15).

Being the first to investigate physical violence against Syrian refugee women in Jordan, this study aimed to investigate lifelong prevalence and current prevalence (last year) of physical abuse. In addition, the study aimed to explore the association of some socio-demographic factors with the occurrence of physical abuse among Syrian refugee women in Jordan.

Methods

Ethical Approval

A descriptive cross-sectional design was used to investigate the prevalence of physical abuse among Syrian refugee women in Jordan. Ethical approval has been gained from the IRB committee in Al al-Bayt University and the Jordanian Ministry of Health. Also, consent to participate in the study was obtained from the women who were invited into the current study.

Population

Participants were recruited from Maternal and Child Health Clinics (MCHCs) in Mafraq governorate. All Syrian women who are able to read and write Arabic language, aged 18 or older, and visited the MCHCs during the period (March 1, 2014 and June 1, 2014) were invited to participate in the study. From the 280 women who were invited to participate, 205 women agreed to participate in the study with a response rate of 73%. However, 23 partially filled questionnaires were excluded from analysis. Accordingly, a convenient sample of 182 women was obtained.

Instrument

The validated Arabic version of the NorVold Domestic Abuse Questionnaire (NORAQ) was applied to measure the physical abuse. Permission to apply the instrument was gained from Linda Haddad who translated and validated the tool (11). The NORAQ questionnaire includes five parts (emotional abuse, physical abuse, and sexual abuse, current experience of abuse, and experience of reporting abuse to primary care personnel.

Table 1: Detailed questions of physical abusive acts

	Physical abuse
Mild abuse	Have you experienced anybody hitting you, smacking your face, or holding you firmly against your will?
Moderate abuse	Have you experienced anybody hitting you with his/her fist(s) or with a hard object, kicking you, pushing you violently, giving you a beating, thrashing you, or doing anything similar to you?
Severe abuse	Have you experienced anybody threaten your life by, for instance, trying to strangle you, showing a weapon or a knife, or by any other similar act?

The last section of the questionnaire included questions on socio-demographic characteristics of the participants, such as age, level of education, marital status, place of residence, family size, household income, marriage age, and working status. Age was categorized into 25 years or less, and 26 years and above. Level of education was also measured by a binary variable: primary education, and secondary or more. Household income distinguished women who live in a household with monthly income of 200 JD or less, and more than 200JD. Place of residence refers to rural and urban.

Procedure

Research assistants where trained to collect the data from the participants. They approached the women in the MCHCs. The questionnaires were distributed and explained to the participants. To ensure confidentiality participants who agreed to participate in the study were asked not to write their names or addresses.

Statistical Analysis

Statistical analysis was performed using SPSS for Windows 19. Descriptive statistics including frequencies were used to describe participants' characteristics. Chi square tests were used to describe association between women's exposure to physical abuse and some socio-demographic variables. Independent samples t test was used to assess for differences in psychological suffering scores between abused women from different socio-demographic groups. Linear regression models were applied to predict the contributing variables to physical abuse. A significance level of .05 was the cutoff point.

Results

Socio-demographic characteristics of the participants

Participants' ages ranged from 19 to 55. Sixty seven women (36.8 %) live in the rural areas and 115 women (63.2%) of them live in the city of Mafraq. Most of the participants (73.1%, N=133) had finished their primary education, and about one fifth (23.1%, N=42) of the participants had graduated from high schools, and only five participants (2.7 %) and two participants (1.1%) had graduated from a college and a university respectively. Most of the sample were married women (78.6%, N= 143) while the rest of the participants were single (9.9%, N=18), widowed (8.2%, N=15), and divorced (3.3%, N=6). Most of the participants' household income was 200 JD or less (88.5%, N=116).

Prevalence of physical abuse by socio-demographic characteristics of the participants

About one third of the participants (57, 31.3%) reported a lifetime experience of physical abuse (before and after refuge). Of these, more than one quarter (25.3%, 46 participants) reported mild physical abuse. Some 44 participants (24.2%) experienced moderate physical abuse. About 14 participants (7.7%) experienced severe physical abuse. The sum of the participants experienced the three types of physical abuse is more than 57 because many of them reported being exposed to more than one type of physical abuse (mild, moderate, and severe).

Twenty seven respondents (14.8%, 27) were exposed to physical abuse during the last year. Twenty two married participants (38.6%) reported that their husbands were responsible for the abuse that they were exposed to, followed by fathers (14%, 8 participants), and brothers (10%, 6 participants). About one quarter of the partcipants

(23%, 43 participants) reported being physically and emotionally abused.

The bivariate analysis revealed that some socio-demographic characteristics are significantly associated with exposure to physical abuse among the Syrian refugee women. For example, educated women were less likely to report exposure to physical abuse than those who are less educated (χ^2=4.43, N = 182, p =0.035). Also, participants who live in households with large family size (6 members and more) were more likely to report being physically abused (χ^2=4.16, N = 182 p =0.041). Older participants (older than 25 years old) reported being exposed to physical abuse more than those who were aged 25 years or less (χ^2=4.57, N = 182 p =0.032). In addition, women who were married before their 20th birthday reported being physically abused more than those who were married in older age (χ^2=3.96, N = 155) p =0.047). However, other demographic groups within the study sample were not significantly associated with physical abuse (i.e. marital status, place of living, and household income).

Higher psychological suffering was reported by the participants who are married, less educated, living in large family size households, and living in urban area (see Table 2). Other factors such as household income, husbands' employment status, participants' age and marriage age showed no significance difference in terms of psychological suffering score.

Regression analysis findings showed that some socio-demographic variables of the participants were contributed to the variance in psychological suffering score (as reported by physically abused women). A significant regression model was found (the enter method was performed), F = 6.1, p = 0.00. The revealed model explains 31.5 percent of the variance in the participants' suffering score. The correlation matrix between the independent variables showed no evidence of multicolinearity. Educational level was the strongest contributor to the variance in the suffering score (Beta= -1.7) followed by marital status and household income with Beta values -1.3 and, 0.94. The regression analysis results shows that women who were educated, not married and have higher household income were less likely to report high scores in the psychological suffering scale.

The association of physical abuse with some mental health disorders was investigated. The findings showed that physical abuse is significantly associated with experiencing depression (χ^2=4.51, N = 182, p =0.034). On other hand, anguish feeling and insomnia were not found to be significantly associated with experiencing physical abuse among the study sample.

Discussion

The current study produced several interesting findings. First of all, though lifetime prevalence of physical abuse against refugee Syrian women was high (31.3 %) (i e it is higher than that in Saudi Arabia (25.7%)) (6). Yet, it seems relatively low compared to the findings of other investigations conducted in the region and other parts of the world. The prevalence rate of lifetime physical abuse of some regional studies' findings is higher, for example, 44.7% among Palestinian refugee women living in Palestinian refugee camps in Jordan reported lifetime physical abuse (3). The reason behind this might be that the Palestinian women in this study were recruited from the refugee camps while Syrian refugee women in the current study are non-camp dwellers. There is no doubt that comparing the current prevalence rates of physical abuse with that of previous research in the regional, refugees and immigrant populations is beneficial. Though, it is worth noting the timeframe and methodological variations among different studies.

Table 2: Relationship between psychological suffering and some socio-demographic variables of the participants (N = 57

	T-test value	Degree of freedom	P Value	CI	Mean	Mean
Marital status	2.2	55	0.035	0.11–2.7	Married 6 .4	Unmarried 5.0
Educational level	4.2	55	0.001	0.56–1.1	Educated 4.1	Less educated 6.5
Family size	-2.1	55	0.05	26–2.4	≤five members 4.9	>five members 6.4
Place of residence	2.4	55	0.016	0.6–2.8	Rural 5.3	Urban 6.6

Disadvantaged socioeconomic circumstances, in which the refugee women live, put them at higher risk of being victims of abuse. Similar to other studies, the results of the current study showed a significant association between low educational level and the likelihood to be a victim of physical abuse (8, 9) In contrast, the current study findings were incongruent with those of the previous research (8, 10) where the household income was not found to be associated with physical abuse. The current study revealed that less educated women and those who live in households with large family size and women who got married before their 20th birthday are more vulnerable to physical abuse. In addition, almost all women who participated in the study are housewives, thus they are financially dependent on their husbands or male family members.

The present study provides further evidence that physical abuse often coexists with emotional abuse among women. The current study findings are congruent with the previous studies (11, 5, 12, 2, 13); 23% of the participants reported that they were physically abused alongside the emotional abuse

A closer look at the current research findings showed that few participants had reported the exposure to physical abuse (one of the most under-reporting types of domestic abuse in the developing world). Only 6% of the Syrian refugee women who participated in the study reported the physical abuse to health care providers.

Limitations

The main limitation of the current study is that it employed a non-probability sampling technique (a convenient sample) which may affect the generizability of the findings. Also, the study participants were non-camp refugees. Thus, further research will be needed to understand the physical abuse phenomena among Syrian refugee women who live in devastating living circumstances in the refugee camps.

Recommendations

This is the first study to report physical violence and its associated factors among Syrian refugee women in a country that hosts refugees. Mental health services are needed and nurses and physicians should be trained to provide proper counseling for these women, particularly because we found a significant association between exposure to physical abuse and poor emotional health suggests a need to integrate mental health and GBV.

Finally, given that we report a relatively high prevalence of physical abuse yet we know current GBV programming for the non-camp population to be inadequate, we suggest an immediate scale-up of GBV interventions to prevent GBV and mitigate its consequences among Syrian refugee women in non-camp settings.

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THE ADVENT OF PRACTICE NURSES

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Abstract

This paper provides an overview of the required qualifications and standards of Practice Nurses in the Primary Care setting as well as an outline of the economic benefits of utilisiing Practice Nurses in a National Health System.

Key words: Practice Nurse, Qualifications, Standards, Economic benefits

Introduction

Practice Nurses are a relatively new addition to general practice/family medicine and an innovation that is being implemented in most countries globally. They offer cost and time savings to clinics and sole general practices, through taking on some roles of general practitioners/ family doctors, thus relieving them for more focused medical duties. Additionally they take on duties that benefit quality care of patients and duties that may benefit the practice financially (e.g. health promotion and monitoring, patient recall, disease prevention, office management, infection control, immunisation) and reduce incidence of adverse events. Practice Nurses have also been found to be a cost saving factor in national Health Budgets. Such Practice Nurses however need appropriate training and there are a range of qualifications for modern day practice nurses , some more general and some specific.

Economic factors

Evidence has shown (1) that there is extensive national health cost saving through the employment and delegation of Practice Nurses (PN) and Advanced Practice Nurses (APN), not just in wages paid but in overall national health budgets. While wages are usually below those of GPs/FPs there is also argument that there should be parity of wages due to PN's involvement in other aspects of health provision.

Perhaps the most important economic aspect to a national health budget is that the cost to train Advanced Practice Registered Nurses (APRNs) for example, is far less than that involved for training a GP/family physician. The rising cost of health care is a concern for individuals, families, businesses, government entities, and society as a whole. Governments are looking to find ways to increase efficiency in the health system without compromising quality of care.

A number of empirical studies support the conclusion that greater utilization of Advanced Practice Nurses can both improve patient outcomes and reduce overall health care costs (2). Reducing the cost of medical care

frees up scarce societal resources to be spent in more productive ways.

Employment of Practice Nurses also alleviates doctor shortages, which is a problem in nearly all countries, and especially in rural and remote areas and developing and middle income nations.

Studies have looked at the employment of Practice Nurses in the economic impact of increased nursing hours of care on health outcomes. In an Australian study in Perth, Western Australia. The number of nursing-sensitive outcomes was 1,357 less than expected post implementation and included 155 fewer 'failure to rescue' events. The 1,202 other nursing sensitive outcomes prevented were 'surgical wound infection', 'pulmonary failure', 'ulcer, gastritis, upper gastrointestinal bleed' and 'cardiac arrest'. (3)

Higher nurse staffing levels and a richer skill mix (a higher proportion of registered nurse (RN) hours) have been linked with improved patient outcomes in many studies (3).

Qualifications and expertise

In almost all countries nursing practice is defined and governed by law, and entrance to the profession is regulated at national or state level.

Globally there are various types of Practise Nurses (PN) and Advanced Practice Registered Nurses (APRN) and Certified Nurse Practitioners (CNP) each with slightly different roles and skill sets.

This paper looks in depth at the model of Practice Nurses adopted in many countries including Australia, USA, Canada, Ireland, New Zealand and the UK and at the various ways such PNs/APRNs can be used to both uphold and improve health care delivery in the general practice/family medicine setting. These skills sets not only concern the everyday workload of a busy practice, they are implemented on tertiary education standards and qualifications and within National Standards and Domains of General Practice/ Family Medicine.

Advanced practice nurses usually have a bachelor's degree in nursing, have practiced for at least several years and then have completed master's level work to qualify to perform advanced tasks. These advanced tasks include delivering babies in uncomplicated births; administering anaesthesia for routine surgeries; and managing primary care tasks for patients, such as routine screening and treatment of relatively straightforward problems.

In 2012, authors of a report issued by the not-for-profit Physicians Foundation noted in its discussion of the safety and quality of nurse practitioners that "the research literature shows, without exception, that within their areas of training and experience, nurse practitioners provide care that is as good as or better than that provided by physicians."(3)

In the USA Advanced Practice Registered Nurses (APRNs) are registered nurses educated to Masters or post Masters level and many are educated for a specific role and patient population. APRNs are educated and certified to assess, diagnose, and manage patient problems, order tests, and prescribe medications. (3)

CNPs are educated and practice at an advanced level to provide care, independently, in a range of settings. CNPs are responsible and accountable for health promotion, disease prevention, health education and counselling as well as the diagnosis and management of acute and chronic diseases. They provide initial, ongoing and comprehensive care to patients in family practice, pediatrics, internal medicine, geriatrics, and women's health. CNPs are prepared to practice as primary care CNPs or acute care CNPs, which have separate national competencies and unique certifications.

The Clinical Nurse Specialist (CNS) is involved with the patient, other nurses and the practice of nursing, as well as the healthcare organization and its system. The CNS is accountable for diagnosis and treatment of health/ illness states, disease management, health promotion, and prevention of illness and risk behaviours among individuals, families, groups and communities.

Other nursing categories are Certified Registered Nurse Anaesthetist (CRNA), nurses who provide anaesthesia care and anaesthesia-related care for patients and Certified Nurse-Midwife (CNM)who provide the full range of primary health care services to women throughout the lifespan, including gynecological care, family planning services, preconception care, prenatal and postpartum care, childbirth, and neonatal care.

Nurse practitioners can deliver as much as 80 percent of the health services, and up to 90 percent of the pediatric care, provided by primary-care physicians, with equal quality and at lower cost, according to a landmark review by the congressional Office of Technology Assessment (OTA) in 1986. (1)

Nurse practitioner roles were introduced in Australia (and in other countries including the USA, Canada, Ireland, New Zealand and the UK) with a range of objectives including improved access to healthcare services via a flexible, innovative, integrated care strategy, and increased continuity of nursing care at an advanced practice level (4).

As with other roles in primary care, nurse practitioners can specialise in particular areas of care (e.g. HIV or aged care), or work with a broader scope (e.g. population health or 'generalist' primary care nursing). This adds capacity to the practice by offering care that may otherwise be unavailable in a [particular practice.

Clinical benefits of a nurse practitioner depend on the opportunities the practice chooses to maximise, including:

• increased access for patients, such as options for more timely appointments and the ability to:

• prescribe medicines

• order and interpret diagnostic tests

• refer patients to other health professionals

• increased choice of practice team member

• contribution to the development of general practice nursing by providing mentoring and education of other nurses in general practice, other members of the general practice team, and nursing, medical and allied health students

• improved continuity including relational continuity and transfer of information within the practice team

• longer appointments with patients who have complex care needs

• improved coordination of care, including case management and improved efficiency of the inter-professional experience

• provision of new services to patients to address population health needs and improve health

outcomes for the community. This may be achieved by: offering clinics to address chronic disease/complex care (such as asthma clinics, anticoagulation clinics, wound clinics, diabetes clinics, dementia management); enhanced telehealth opportunities; preventive models; patient education; meeting targets around national screening programs (bowel, prostate, breast and ovarian cancers); immunisation; weight loss

and smoking cessation programs.

• opportunities to enhance teamwork within the practice (e.g. reconfigure business processes; patient streaming - beyond the opportunities offered by employing a general practice nurse).

Economic benefits include opportunities to:

• generate new revenue streams through health billing and gap fees, and potentially by working differently as a practice team

• realise cost efficiencies, e.g. by increasing practice capacity while reducing average cost per consultation

• remove unnecessary duplication of work in cases where patients might otherwise see a nurse practitioner rather than a general practice nurse and general practitioner. Nurse practitioner contracts can be structured in a number of different ways, ranging from employee to independent contractor, with or without sharing of revenue from MBS (or other national) items.

Other benefits include:

• potential to improve patient satisfaction and health outcomes as a result of the clinical benefits

described above

• opportunities to reconfigure how the practice team works - e.g. to improve teamwork and enhance shared patient encounters - leading to greater job satisfaction for all team members

One nurse practitioner noted that the role brought greater satisfaction for her than previous roles as a general practice nurse, as she carries greater responsibility and works more autonomously.

• address workforce issues and potential shortages while offering a more efficient mix of clinical skills within the overall practice team - the right person delivering the right level of service at the right time

• better manage workflows - e.g. reduce waiting time to access health care by offering patients the choice of a nurse practitioner where appropriate

• improved work-life balance for practice owners and the general practice team.

What can a nurse do in general practice?

The Nursing and Midwifery Board of Australia (NMBA) defines the scope of practice of a profession as the "full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform" (5). Not all elements within a scope of practice are unique to a specific profession, with elements of service delivery potentially overlapping. Additionally, external factors such as the environment, including legislation, policy, education, standards, the specific clinical setting and population health needs will influence the scope of practice. The scope of practice of an individual nurse may be more specifically defined to reflect the individual nurse's "education, clinical experience and demonstrated competency"in the specific clinical setting. The NMBA has developed a national decision making framework to guide nurses' in making decisions about whether a particular aspect of care or service delivery is within their individual scope of practice. (5)

The Standards (6)

The 22 Standards for practice are presented in the four domains that reflect the breadth of nursing in General Practice. Professional practice includes those standards that relate to aspects of nursing in General Practice concerning the professional role. Nursing care reflects the clinical delivery of nursing services to consumers in General Practice. The General practice environment incorporates aspects of the nursing role that are organisational or environmental in nature.

These Standards reflect the aspects of the nursing role unique to the general practice context and different from those which would be expected of the nurse in other clinical settings.

Professional Practice

Standard 1. Demonstrates an understanding of primary health care principles and nursing in general practice.

Standard 2. Provides nursing care consistent with current nursing and general practice standards, guidelines, regulations and legislation.

Standard 3. Actively builds and maintains professional relationships with other nurses and regularly engages in professional development activities.

Standard 4. Advocates for the role of nursing in general practice.

Standard 5. Demonstrates nursing leadership.

Nursing Care

Standard 6. Demonstrates the knowledge and skills to provide safe, effective and evidence based nursing care.

Standard 7. Undertakes nursing assessment and plans ongoing care.

Standard 8. Effectively implements evidence-based health promotion and preventive care relevant to the Practice community.

Standard 9. Empowers and advocates for consumers.

Standard 10. Understands diversity in the Practice community and facilitates a safe, respectful and inclusive environment.

Standard 11. Effectively delivers evidence-based health information to improve health literacy and promote self-management.

Standard 12. Evaluates the quality and effectiveness of nursing care.

General Practice Environment

Standard 13. Demonstrates proficiency in the use of information technology, clinical software and decision support tools to underpin health care delivery.

Standard 14. Effectively uses registers and reminder systems to prompt intervention and promote best practice care.

Standard 15. Understands the context of general practice within the wider Australian health care system, including funding models.

Standard 16. Contributes to quality improvement and research activities to monitor and improve the standard of care provided in general practice.

Standard 17. Participates in the development, implementation and evaluation of relevant policies and procedures.

Standard 18. Monitors local population health issues to inform care and responds to changing community needs.

Standard 19. Effectively manages human and physical resources.

Collaborative Practice

Standard 20. Builds and maintains professional and therapeutic relationships with consumers, their families and/or support person(s).

Standard 21. Effectively communicates, shares information and works collaboratively with the general practice team.

Standard 22. Liaises effectively with relevant agencies and health professionals to facilitate access to services and continuity of care.

Nurses have the knowledge and ability to provide comprehensive, evidence-based nursing care in the general practice setting. Nurses are integral to planning, implementing, co-ordinating, monitoring and evaluating health care within General Practice. This involves not only assessment and management of the immediate problem, but also includes health screening, preventive care, understanding the social and psychological context, health promotion and health maintenance.

To provide high quality nursing care, the nurse will effectively use a range of communication strategies, sensitive to the individual's values, beliefs, culture, sexual orientation, gender identity and personal context. The nurse will also empower the consumer by supporting their health literacy and the development of appropriate self-management skills. Where necessary, the nurse will also advocate for the consumer and their needs. To ensure that services are meeting the needs of individual consumers and/or the Practice population, nurses will reflect on the quality and effectiveness of their practice.

Nurses in General Practice build and foster relationships with their Practice population, members of the general practice team, other health professionals, community agencies and other organisations to optimise outcomes for consumers. Given the close and often ongoing relationship between nurses and consumers, their families and/or support person(s), nurses are ideally placed to assess and manage a range of health needs. Nurses in General Practice recognise when it is appropriate to consult with, or refer to, other members of the general practice team. Nurses are often recognised as leaders in collaboration with others to enable the integration of care, particularly in the general practice setting.

The following Standards fare rom: NATIONAL PRACTICE STANDARDS for NURSES IN GENERAL PRACTICE, Australian Nursing and Midwifery Federation. Standards are funded by and Copyright to the Australian Government Department of Health.

Domain 1: Professional Practice

STANDARD 1

Demonstrates an understanding of primary health care principles and nursing in general practice.

Performance Indicators

- Identifies and responds to the health and social needs of the local community.
- Integrates an understanding of the health and social needs of the Practice and/or local community into the delivery of nursing care.

STANDARD 2

Provides nursing care consistent with current nursing and general practice standards, guidelines, regulations and legislation.

Performance Indicators

- Critically evaluates how standards, guidelines, regulations and/or legislation can be translated and integrated into practice.
- Mentors other nurses and health professionals in the application of specific standards, guidelines, regulations and/or legislation.
- Evaluates the impact of standards, guidelines, regulations and/or legislation on service delivery, clinical care and/or health outcomes.
- Provides feedback to reviews of standards, guidelines, regulations and/or legislation.

STANDARD 3

Actively builds and maintains professional relationships with other nurses and regularly engages in professional development activities.

Performance Indicators

- Leads networks of nurses in general practice, facilitating orientation to general practice and networking and/or mentoring relationships.
- Acts as a mentor or professional role model for other nurses in general practice.
- Undertakes and facilitates peer appraisal of nursing in general practice.
- Critically reflects on own clinical performance and actively seeks external critical review of clinical practice.
- Contributes to the professional development of other nurses in general practice.
- Participates in the delivery of local continuing professional development opportunities.

STANDARD 4

Advocates for the role of nursing in general practice.

Performance Indicators

- Seeks opportunities to raise the profile of the nursing profession and its role in general practice within the broader community.
- Works in collaboration with local, State/Territory and/or national groups to inform and advocate for nursing in general practice and contribute to workforce planning.

STANDARD 5

Demonstrates nursing leadership.

Performance Indicators

- Participates in the generation of evidence to support the effectiveness of nursing in general practice.
- Contributes to the development of business cases for nursing in general practice.
- Participates in the strategic planning of nursing services within the Practice.

- Identifies and seeks opportunities for funding or additional resources to support service delivery, evaluation activities or research within the Practice.
- Acts as a nurse consultant in areas of particular clinical expertise.
- Demonstrates involvement in leadership activities within nursing and/or general practice groups at a State/Territory and/or national level.
- Actively promotes health, wellbeing and fitness to practice amongst the nursing and general practice team.

Domain 2: Nursing Care

STANDARD 6

Demonstrates the knowledge and skills to provide safe, effective and evidence-based nursing care.

Performance Indicators

- Critically evaluates relevant clinical guidelines and/or primary research to inform nursing care.
- Identifies areas of practice that are not currently based on evidence and explores the available evidence to guide practice.
- Safely, effectively and appropriately provides expert clinical care relevant to the individual consumer.
- Expresses high level understanding of the pathophysiology behind, and management of, the diverse range of health issues encountered within general practice.
- Supports activities to evaluate the translation of evidence into practice.
- Provides education relating to evidence based initiatives and processes, to members of the general practice team.

STANDARD 7

Undertakes nursing assessment and plans ongoing care.

Performance Indicators

- Demonstrates proficiency in a range of advanced health assessment skills within the RN scope of practice.
- Effectively and appropriately uses advanced health assessment skills to evaluate health status and/or risk of developing disease.
- Accurately interprets the findings of diagnostic tests within the scope of RN practice.
- Integrates the findings from validated assessment tools and diagnostic tests with health assessment information to develop an individualised plan of care.

STANDARD 8

Effectively implements evidence-based health promotion and preventive care relevant to the Practice community.

Performance Indicators

- Collaborates with members of the general practice team to identify new opportunities for the Practice to undertake health promotion and/or preventive care activities.
- Establishes systems, in collaboration with the general practice team, to ensure that health promotion and preventive care is evidence-based consistently delivered and regularly evaluated across the Practice.
- Identifies and plans nursing services to meet population specific needs for health promotion and/or preventive care.
- Designs and implements relevant, evidence-based opportunistic health screening programs across the Practice.

STANDARD 9

Empowers and advocates for consumers.

Performance Indicators

- Advocates for the needs of the Practice population with external groups, including service providers, councils and other health professionals.

- Supports consumers to raise relevant issues with external groups, including service providers, councils and other health professionals.
- Takes a risk based approach in advocating for and empowering consumers.

STANDARD 10

Understands diversity in the Practice community and facilitates a safe, respectful and inclusive environment.

Performance Indicators

- Takes a leadership role in developing a professional relationship with diverse groups in the local community.
- Works with diverse groups to develop, implement and evaluate specific programs to engage them within the Practice community.
- Promotes access to general practice services by diverse groups in the local community.
- Creates and/or provides resources that specifically meet the needs of consumers from diverse groups.
- Takes an active role in managing factors that seek to disrupt the provision of a safe, respectful and inclusive environment.
- Facilitates education for members of the general practice team around the specific needs of relevant diverse groups in the local community.

STANDARD 11

Effectively delivers evidence-based health information to improve health literacy and promote self-management.

Performance Indicators

- Develops education/self-management resources relevant to the Practice community.
- Critically evaluates the strategies used by the nursing team to facilitate health education and promotion of self management.
- Integrates evidence based principles in the delivery of health education and self management support.
- Supports other nurses in the development and/or delivery of health education and consumer self-management.

STANDARD 12

Evaluates the quality and effectiveness of nursing care.

Performance Indicators

- Takes a leadership role in critically evaluating potential or actual risk, near misses and/or safety breaches related to nursing care and develops a plan to minimise future events.
- Leads activities within the nursing team around quality improvement related to nursing care.
- Establishes and monitors key performance indicators appropriate to the model of nursing care.
- Works with other nurses in general practice on nursing quality improvement issues across Practices at a local, State/Territory and/or national level.
- Appropriately disseminates information relating to quality improvement to nursing and/or general practice groups.

Domain 3: General Practice Environment

STANDARD 13

Demonstrates proficiency in the use of information technology, clinical software and decision support tools to underpin health care delivery.

Performance Indicators

Infection control

- Understands the importance of, and, undertakes regular data checking and cleansing.
- Conducts audits of Practice data using relevant IT systems and contributes to planning a response to the findings.
- Initiates education of the general practice team around identified issues related to data quality.

- Critically evaluates the use of IT in the delivery of nursing care.
- Acts as a mentor to support the development of clinical IT skills in other nurses and members of the general practice team.
- Seeks out innovations in IT to support the delivery of nursing care in the Practice.

STANDARD 14

Effectively uses registers and reminder systems to prompt intervention and promote best practice care.

Performance Indicators

- Identifies a population health clinical need and initiates new recall and reminder systems and/or registers as required.
- Critically evaluates the safety and effectiveness of Practice recall and reminder systems and/or registers.
- Develops and implements systems and processes to identify near misses in relation to recalls and reminders.
- Undertakes audits of Practice registers to identify potential areas of clinical improvement.

STANDARD 15

Understands the context of general practice within the wider (Australian) health care system, including funding models.

Performance Indicators

- Maintains detailed and current knowledge of the various funding streams available to general practices.
- Actively participates in the development of business cases, including health outcomes evidence and financial implications, to support nursing in general practice.
- Provides leadership in developing nursing models to meet the changing context of general practice.

STANDARD 16

Contributes to quality improvement and research activities to monitor and improve the standard of care provided in general practice.

Performance Indicators

- Collaborates with other members of the general practice team to initiate Practice-wide quality improvement and/or research activities.
- Takes a leadership role in the accreditation process, in relation to nursing roles and responsibilities.
- Identifies and prioritises quality issues within the Practice.

STANDARD 17

Participates in the development, implementation and evaluation of relevant policies and procedures.

Performance Indicators

- Critically evaluates policies and procedures based on evidence and changes in the environment of general practice.
- Takes a leadership role in the development, implementation and evaluation of Practice policies and procedures.
- Anticipates risk and potential for adverse events related to policies and procedures.
- Contributes to, and/or initiates the development, implementation and evaluation of policies and/or procedures for nursing in general practice at a local, State/Territory and/or national level. National Practice Standards for Nurses in General Practice

STANDARD 18

Monitors local population health issues to inform care and responds to changing community needs.

Performance Indicators

- Analyses and interprets current population health data to inform improvements in nursing care and/or service delivery in the Practice.

- Anticipates community population health needs related to local changes in the community demographics, physical environment and the social determinants of health.

STANDARD 19

Effectively manages human and physical resources.

Performance Indicators

- Contributes to the development of proposals/briefs for additional resources.
- Develops, implements and monitors systems for managing supplies and equipment within the Practice.
- Critically analyses resource utilisation.
- Manages a budget for nursing services and/or equipment.
- Recognises alternative resources, supplies and/or equipment that could improve service delivery

Domain 4: Collaborative Practice

STANDARD 20

Builds and maintains professional and therapeutic relationships with consumers, their families and/or support person(s).

Performance Indicators

- Provides mentorship to other members of the general practice team to support communication and relationship building.
- Proactively seeks to establish ongoing relationships with members of the Practice community.

STANDARD 21

Effectively communicates, shares information and works collaboratively with the general practice team.

Performance Indicators

- Develops and implements strategies to share clinical information between members of the general practice team.
- Proactively seeks to contribute to the development of communication skills in all members of the general practice team.
- Demonstrates a leadership role in developing a culture of collaboration within the nursing and general practice teams.
- Critically evaluates the nature of collaboration and/or teamwork within the Practice.
- Identifies potential strategies to enhance collaboration and/or teamwork within the Practice.
- Seeks to engage all members of the nursing and general practice team in collaborative practice.

STANDARD 22

Liaises effectively with relevant agencies and health professionals to facilitate access to services and continuity of care.

Performance Indicators

- Critically evaluates and seeks to address gaps in local service provision.
- Actively seeks to expand opportunities for the Practice community to access local services.
- Co-ordinates care for those with complex conditions, acting as a liaison between health professionals.
- Leads the development of strategies to promote equitable access to services.

Acknowledgement : NATIONAL PRACTICE STANDARDS for NURSES IN GENERAL PRACTICE
Australian Nursing and Midwifery Federation Standards funded by the Australian Government Department of Health

PNs in the Middle East

The Middle East region has economies ranging from some of the poorest in the world to some of the wealthiest. Universal health care is available in some countries and not in others. All countries however can benefit from reduced health spending on a national basis - and quality improvement in care given.

The Middle East also has some unique problems in that many health professionals, and particularly nurses, are imported from abroad thus resulting in a unique set of problems, particularly of a communication and cultural nature. In some countries of the Middle East, the expatriate nursing workforce may be as high as 80% (7). Expatriate nurses are a transient workforce, and this also results in a lack of stability in creating a nursing workforce, which further presents a challenge in establishing and sustaining indigenous nursing developments.

The aim of the nursing community worldwide is for its professionals to ensure quality care for all, while maintaining their credentials, code of ethics, standards, and competencies, and continuing their education. While some western countries are the front-runners in advancement of technology and other modern developments, the Middle East is not very far behind.

The notable factor in the Middle East is that the caregiver and the caretaker are all from different countries. The indigenous growth of nursing across the region has been affected by a strong history of medicine, a culturally derived poor perception of nursing and a readily available and majority expatriate nursing workforce.

There is now recognition in individual countries, that to develop and make progress in health services, the recruitment of local nationals to nursing is important for growth of the role of the nursing profession in the delivery of health services. In Bahrain, for example, there are two universities providing undergraduate nursing and greater numbers of young Bahraini women and men are applying for entry to nursing. In the most recently established university (RCSI; www.rcsibahrain.edubh), the number of Bahraini student nurses commencing the programme between 2006-2014 increased by over 150% and the number of males entering the programme increased by 25%. (7)

Conclusion

Nurses have always been an invaluable an often unacknowledged part of all health systems but their introduction into general practice and a range of other specialised medical practices allows for better all round patient care and documented decrease in national health costs.

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THE FUTURE HOME HEALTH CARE IN THE MIDDLE EAST REGION: PART I - INTERNATIONAL PERSPECTIVE

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Abstract

This review is part of a series of papers on home health care. Home health care has gained widespread acceptance recently in the developed and developing countries. This move is affected by the aging of the population, the improvement in medical technologies and the effort to improve quality and reduce cost. The home services vary from nursing care to the concept of hospital at home. The first part of this paper deals with a general view of home health care. It presents the American and Chinese models.

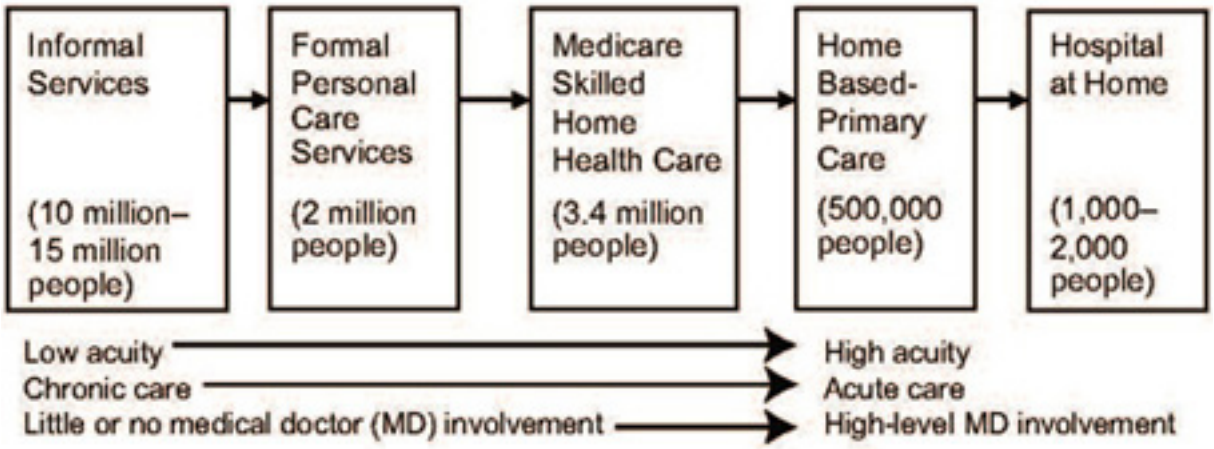
Background

A 2011 report by the National Research Council (NRC) in the USA proclaimed, ""Health care is coming home". The report additionally noted that in spite of the fact that the expenses of care are one driver of this change, the conveyance of services at home is esteemed by people and can advance well living and prosperity when it is overseen well. Living autonomously at home is a need for some, particularly people who are maturing with or into incapacity. However, both the intricacy and the amount of health care services given in home settings are expanding.

Also, people with disabilities, interminable conditions, and functional hindrances require a wide scope of services and backup to continue living freely. However, frequently there is not a solid connection between care delivered in the home and the fundamental social services and back up for autonomous living. Home healthcare organizations and others are adapting to present circumstances of taking care of the necessities and requests of these populations to remain at home by investigating different models of care and reimbursement approaches, the best utilization of their workforces, and advances that can improve autonomous living. These difficulties and openings prompt the thought of how home services fits into the future healthcare framework.

Moving from left to right, Figure 1 demonstrates that this continuum ranges from look after for lower-acuity levels care to higher acuity, and from chronic care to more acute care. It additionally moves from models in which there is almost no physician contribution in the home toward models in which MD inclusion is significant. The figure demonstrates that this range begins with casual care services delivered at home, frequently by relatives-commonly, daughters, life partners, or daughters-in-law. In the United States estimates propose that somewhere close to 10 million and 15 million individuals at present get such care in the home (Leff et al , 2005).

Figure 1: Home health care across the spectrum of services and supports, including numbers of individuals receiving care.



Source: Bruce Leff and Elizabeth Madigan, 2014.

Next, moving right, is formal individual care services-that is, fees-for services for individuals who require extra help or who don't have family at home to help them. An expected 2 million Americans get this formal help (Leff et al 2005). Next is skilled home health care, which is used for post-acute care, and in addition for individuals who are homebound, and have skilled home health care needs. More than 3 million Medicare recipients use those services.

More to the right is home-based primary care, which includes doctors, nurse practitioners, or physician assistants giving longitudinal medical care, which is frequently group based care and which is regularly given in coordinated effort by social services suppliers to a population that is basically homebound. It is projected that at least 500,000 individuals in the United States get these services. Lastly, on the most distant right of Figure 1-1 are acute care, hospital-level services delivered in the home, including care delivered through hospital-at-home-type models, such as the model developed by the Johns Hopkins Schools of Medicine and Public Health. To date, Less individuals receive these more intensive home-based services (Leff et al. 2005).

Leff noticed that the move from left to right in Figure 1-1 involves a move from the provision of health care services to individuals with lower-acuity levels of need to individuals with higher-acuity needs involving a blend of acute and chronic care services and, lastly, to provision of acute care in the home. It additionally moves from models with next to zero doctor inclusion to those in which contribution is considerable.

The four primary elements driving the improvement and utilization of this range of-care methodologies are policy, payment, technology, and demographics. Much consideration is paid to the last element, as it is expected that we suspect the maturing of the American population, the anticipated increment in the quantity of individuals with different multiple chronic conditions or functional impairments, and the impact that it's going to have on the health care system, that growth is a constant, whereas the other elements -policy, payment, and technology-are amenable to change.

The present array of chronic care and home-based services is not well coordinated. Patients may be lost in the system not knowing who is delivering the services.

In a genuine health care system, home health care services, would be incorporated into the mainframe, and those giving these services would deliver care along a continuum that would include collaborations with partners in the community as well as those in facility; based long-term care, because patients often end up there at least for short periods, before going home again and receiving home health care services.

Advantages of Home-Based Care

Home health care offers some essential, rational points of interest inside the continuum of health services that are as genuine today. These points of interest include:

o An upgraded perspective of patients and parental figures that prompts a superior comprehension of essential issues, similar to how they oversee solutions and nourishment;

o Access to medical services that are most important to patients with physical and financial hindrances to care;

o A more personal clinician-patient relationship "around the kitchen table,"

o Clinician articulation of a demonstration of lowliness that exhibits that clinicians have left their usual range of familiarity to be on their patients' turf and that the patient and family merit being really known;

o Lower costs for services that are sought more by numerous patients;

o And sometimes, more noteworthy wellbeing for fragile senior citizens, since they will have less of the basic complexities of hospitalization, for example, delirium

In view of these points of interest, the home and community will develop later on as the fundamental settings for a horde of health care services. The home setting and health care services and backings will turn out to be synonymous to the point that they may not be called home care; rather, they will simply be modern health care.

Home-focused care is fixated on the patient, offering comprehensive, modern, and individualized practice to look after individuals with genuine and impairing conditions. Home-focused care will develop into a noteworthy national strategy for the arrangement of medical services since its advantages for both payers and patients are so intense.

Current State of Home Health Care in the United States

Population patterns are driving the shape and extent of home healthcare services. Medicare statistics showed that many people have at least three chronic conditions (65 percent), half live beneath the destitution line, almost one third (31 percent) have a psychological or mental impedance, and around 5 percent live in long-term facilities (Kaiser Family Foundation, 2014).

Moreover, despite the fact that the inclination is to bump the Medicare population into one gathering, around 16 percent of Medicare enrollees are people with inabilities, more youthful than the age of 65 years and 13 percent are matured 85 years and older. Notwithstanding these difficulties, Medicare recipients are regularly in reasonable or weak health, as indicated by self-evaluations, and have at least two issues with exercises of everyday living (ADLs).

The development in the span of this population is contrasted by the numbers of Americans aged 65 years and older in 2002 (35.5 million) and 2012 (43.1 million). Gauges for 2040 are that somewhere in the range of 80 million Americans will be age 65 years and older, and around 29 million of those people will have some level of disability. In the interim, the quantity of Americans aged 85 years and older is anticipated to develop from 5.9 million today to around 14.1 million in 2040.

The quantity of organizations giving home health care in the United States developed from 8,314 in 2005 to 12,613 in 2013, Medicare payments for home healthcare services almost multiplying from 9.7 billion in 2001 to about $18.3 billion in 2012. Home health care services constitutes just around 3 percent of Medicare welfare installments.

The Medicare Home Health Care Program

Individuals who are perceived as requiring home health care are the individuals who have had a current hospitalization or the individuals who have a doctor referral.

The beneficiary must be under the care of a doctor who has set up an arrangement of care for the patient (a necessity over which the home health agency does not have control);

o The care plan must incorporate the requirement for nursing care or physical, speech, or occupational therapy;

o The beneficiary must get care through a Medicare-guaranteed home health organization; and

o The beneficiary must be homebound and not able to leave the home unaided without the likelihood of hazard.

Two noteworthy suppositions underlie these qualification criteria. The doctor drives the care and the patient has certain necessities (from a clinical point of view and in light of the fact that he or she is homebound). Moreover, if a recipient needs talented nursing care, that care must be required just discontinuously or part time and must be given by an enlisted nurse (RN) or an authorized practice nurse regulated by a RN.

Home health aide wellbeing should complement the care delivered by experts. Extra services that might be given incorporate restorative social services and medical supplies. Services that are not secured incorporate 24-hour care, food, and individual care not related with treatment or nursing. In a few states, in any case, Medicaid covered these services for low-pay inhabitants prior to the trump government.

Medicare recipients get talented care in the home on an intermittent premise. The talented care look after a specific timeframe-commonly, 60 days-and skilled care can be reestablished if the recipient needs such services for a longer time. Conversely, business insurers back up plans ordinarily approve a specific number of visits (5 or 10, for instance).

Unskilled services help individuals securely remain in their own particular home for the longest timeframe, and in spite of the fact that these services are not covered by Medicare's home health care services program, they might be canvassed in different ways or paid for out-of-pocket that usually is unaffordable. An outstanding model of exhaustive non institutional care is the Program of All-Inclusive Care for the Elderly (PACE), a program mutually financed by Medicare and Medicaid that gives a coordinated arrangement of care at a PACE center in the community, with some home health services bolster, for nursing home-qualified beneficiaries.

Quality Measures

National home health care quality measures assembled for the Centers for Medicare and Medicaid Services' Home Health Compare site propose that home health organizations give fantastic services as indicated by key process measures with home health agencies giving:

o Checks for depression and the danger of falls 98 percent of the time,

o Instructions to relatives 93 percent of the time, and

o Timely start of patient care 92 percent of the time.

The normal execution is to some degree inferior for health outcome measures, which, to a limited extent, mirrors the debility of individuals who require home services. For instance, some performance measures show:

o Postsurgical wound care or mending 89 percent of the time,

o Reduction of agony when moving around 68 percent of the time,

o Improvement in strolling or moving around 62 percent of the time, and

o Readmission to health care facility healing center inside 60 days 16 percent of the time.

Overall, the home health care field, is accomplishing similar readmission rates as hospitals, in spite of the fact that, the hospital readmission rate is ascertained just on the premise of readmission in the initial 30 days after the patient is discharged and, in this way, is to some degree less demanding to accomplish.

At last, how do recipients themselves rate the home health care services that they have received? Once more, utilizing national midpoints from Home Health Compare,

o Seventy-nine percent of patients say that they would prescribe their home health care services organization to loved ones;

o Eighty-four percent gave the general care that they got from the home health care services organization a rating of 9 or 10 on a 10-point scale;

o Eighty-four percent detailed that the home health care services team debated solution, torment, and home wellbeing with them; and

o Eighty-five percent said that the home health care services group conveyed well.

Reimbursement

Lately, the government has cut Medicare repayment for home health care services, and sooner rather than later, another $25 billion "will be removed from the home health care services framework". Another wellspring of cuts has come about because of states' moves to oversee long term care for Medicaid beneficiaries, which has diminished the quantity of hours of patient care given in the home. Extra diminishments in business payers' repayments, and in Medicare Advantage, Medicare's overseen care program, have happened.

More money related difficulties result from the abnormal state of examination and reviewing to which home health agencies are subjected, which have been brought about partly from extortion and mishandling in the system.

Emerging Innovations

Home health care suppliers are included with various developing models that sort out and pay for care differently. Among them are developments that were built up under the Patient Protection and Affordable Care Act of 2010 (ACA), for example, accountable care organizations (ACOs) and packaged installment plans. In particular:

o Home health care associations are discovering chances to work specifically with ACOs to convey community based care.

o Home health care associations are included with the arrangement of post-intense care benefits that include the utilization of both home health care and talented nursing to give the correct level of care after hospitalization.

o Increasingly, home health care associations are included with transitional care, in which their first visit to the patient is in the hospital and afterward they make maybe one visit after the patient is released.

o Home health care associations' patient appraisal aptitudes and experience working in the house are being tapped for assessments of high-hazard enrollees in health plans.

The test is to take care of the expense of these services extensions. The foundation of home health agencies has been worked around Medicare, and these new plans oblige organizations to work in an unexpected way. Everything from programming frameworks to care conveyance models should be upgraded, and mentalities should be balanced. Moreover, rivalry in these rising fields is huge: "Everyone needs to be in this space at this moment". Coordination among the different elements giving transitional care-the hospital, the insurance agency, and others-is not effortlessly accomplished.

For quite a while, despite the fact that home health care services have tended to utilize electronic records for both the accumulation of clinical data and survey, important utilization arrangements under the ACA don't have any significant bearing on long term care. Home health care additionally has not profited from the trading of clinical information with different suppliers, nor do home health agencies have the patient portals that hospitals are required to give their patients. Bigger home health

organizations are giving careful consideration to revealing and investigation of quality outcomes, yet littler ones experience difficulty paying for information examination and electronic records frameworks.

At long last, telehealth applications (e.g., video, remote observing, automated calls) have been observed to be successful and financially savvy by a few associations. Be that as it may, no extra repayment is accommodating the improvement and utilization of telehealth, a lack that is restricting the trend.

Elements for Progress

Four principle elements will be expected to impact this development and can be set up by all assortments of payers and associations:

o Development and oversight of interdisciplinary Home health care arranged by doctors and practice nurse educated by established ideas of all encompassing geriatric medicine, palliative solution, and restoration medicine;

o Enhanced care transitions that tackles self-administration, care coordination, data exchange, and clinical adjustment;

o A capacity for raising the power of therapeutic and palliative care at home in times of decreased or compounding of a patient's disease or restorative condition (counting acceleration to doctor's facility like administrations at home); and

o The mindful utilization of cutting edge data innovation between experiences to help with the administration of issues that emerge amongst visits and to enhance triage and the general effectiveness of care.

The absolute most essential issue is figuring out if the capability of home-focused care is acknowledged and the pace at which it will be acknowledged is the quality of the country's Medicare-affirmed home health organizations. These associations exist in every community; and utilize a huge number of staff who are attendants, advisors, different clinicians, and helpers; who make more than 100 million home visits every year; and aggregately, have numerous solid community ties.

An arrangement of strategies that would bolster the home medical services foundation and help it assume the function would

o Tie installments to results and encounter and encourage supplier interest in an assorted scope of installment option models;

o Enable the contracting of medical chiefs (who might, for instance, connect home health services to the services offered by other key suppliers);

o Have interdisciplinary group case surveys, like the approach utilized by hospices;

o Make the mediations utilized amid the move of care, a secured home health services benefit, independent of whether a patient is homebound;

o Facilitate innovation to enhance the stream of data among suppliers and between home care organizations and the patients and families served; and

o Advance training and preparation of professions for organization staff in state-of -the-art geriatric, palliative, and rehabilitation medicine, and in procedures for the coordination of care.

This focal part would be further supported, by making real misrepresentation and mishandling concerns a relic of past times. Later, home care agencies ought to certify not exactly at the season of licensure but rather on a progressing premise. Chosen use measurements ought to be freely announced. Esteem based acquiring and oversight models ought to diminish fluctuation crosswise over organizations, and endeavors ought to be made to weed out less able elements. In the event that this were done, even the Medicare-guaranteed home health agency of 2024 with the most minimal level of execution would be "a genuine and gifted clinical association with the ability, culture, and innovation [required] to be a center for some portion of helping doctors and home attendants addressing Medicare cost and quality difficulties."

The best models and approaches and the assets and strategies required for achievement will be recognized after some time. All in all, a brilliant home-focused health system is plainly and substantially before us on the off chance that we keep on nurturing the seeds of progress that are beginning to develop, while finding a way to advance as opposed to decreasing our home health organizations.

Lessons From Japan and China

In Asia, home health care model needs to be adapted to locally based on the socioeconomics of the population and different difficulties.

In China, the size of the population and the associative difficulties can be difficult to envision. By 2020, China will spend more than the United States on health services, despite the fact that they are spending far less per capita than the United States. One of the difficulties in managing the maturing population in China is the one-child family. They now have a normal couple attempting to deal with four, now and again eight individuals, if the colossal number of grandparents are alive. Despite a centuries-in length social convention of obedient devotion and predecessor adoration, the Chinese government in 2013 joined some different nations in receiving a law saying that individuals needed to deal with their maturing guardians' money related and profound necessities.

China's developing elderly population, consolidated with its vacillating financial difficulties, is driving some truly

inventive approaches. An approach test that the Chinese face, as do numerous nations, is the separation of the medical care and social care parts. The segments need to join their assets with private family assets to empower a group to choose in a complete, adaptable manner what an individual or family needs most. This is as opposed to installment frameworks that oblige assets to be utilized as a part of particular ways.

Examination of the quantities of specialists and nurses in China, particularly those trained in geriatric care, stacked up against the developing need shows such a sizable needs, to the point that plainly the nation can't depend on a doctor and caretaker driven model. The greater part of these individuals will never at any point approach a doctor or caretaker in their lifetimes. The nation should embrace a community health worker-driven approach that can likewise enroll family individuals and neighbors in some really concentrated ways. The fate of care is group based, cooperative, comprehensive, and in the community.

China is presently attempting to build up a technique concentrated on making a community mind workforce, foundation, and plan of action. In truth, such a model can serve individuals of any age, so the contention for it can be founded on universal design principles. The model that the Chinese are attempting to construct is "care-flow service networks " that will permit various organizations and agencies- government service providers, benefit providers, service providers, or family-to utilize a typical infra-structure to convey care in the community and, in the meantime, permit significant development in the applications utilized and services provided.

The Chinese are as of now building savvy stages in view of exercises of regular day to day existence-railroad utilization, correspondence, shopping, and telephones and various technology They are not contemplating health services in segregation, as frequently occurs in the United States, expecting that "everything else" is some way or another dealt with. They have as a top priority an entire social engagement framework that incorporates the services required for protected and secure living.

Without a doubt, some portion of the test for the Chinese in outlining this complete administration framework is managing the scale contrasts from little rustic settings to medium-sized towns to the current huge urban areas. Approximately 20 new megacities that will have this old-age-friendly city foundation set up are being worked without any preparation. The national government's present 5-year plan includes beginning these, and by 2020, the Chinese would like to give 90 percent of care to older individuals in their homes.

Personal Health

In the United States, what business procedures and development techniques can change the model of care? By 2017, the US will have more individuals on the planet who are over 65 than under the age of 5 years old for the first time in mankind's history. Aging population and rising health care expenses are concerns around the world. Numerous nations are "managing the triple point improving the nature of patient care, enhancing population wellbeing, and diminishing the general cost of care. They see the requirement for senior services overwhelming the workforce, delivering medical services specialist deficiencies and making migration challenges far and wide.

What they are longing to do is to "move left," that is, to get more individuals on the finish of the health continuum with lower levels of chronic illness, bring down levels of functional impairment, bring down expenses of health care, and a higher personal satisfaction.

Advancements in policy or innovation may encourage governments to fulfill the move to one side in the outline in Figure 1. The relocation of technologies that help that happen are now happening. This relocation of technologies brings up huge issues for the United States, including the accompanying:

o What are the wellbeing and security suggestions?

o What does this movement mean from an administrative point of view?

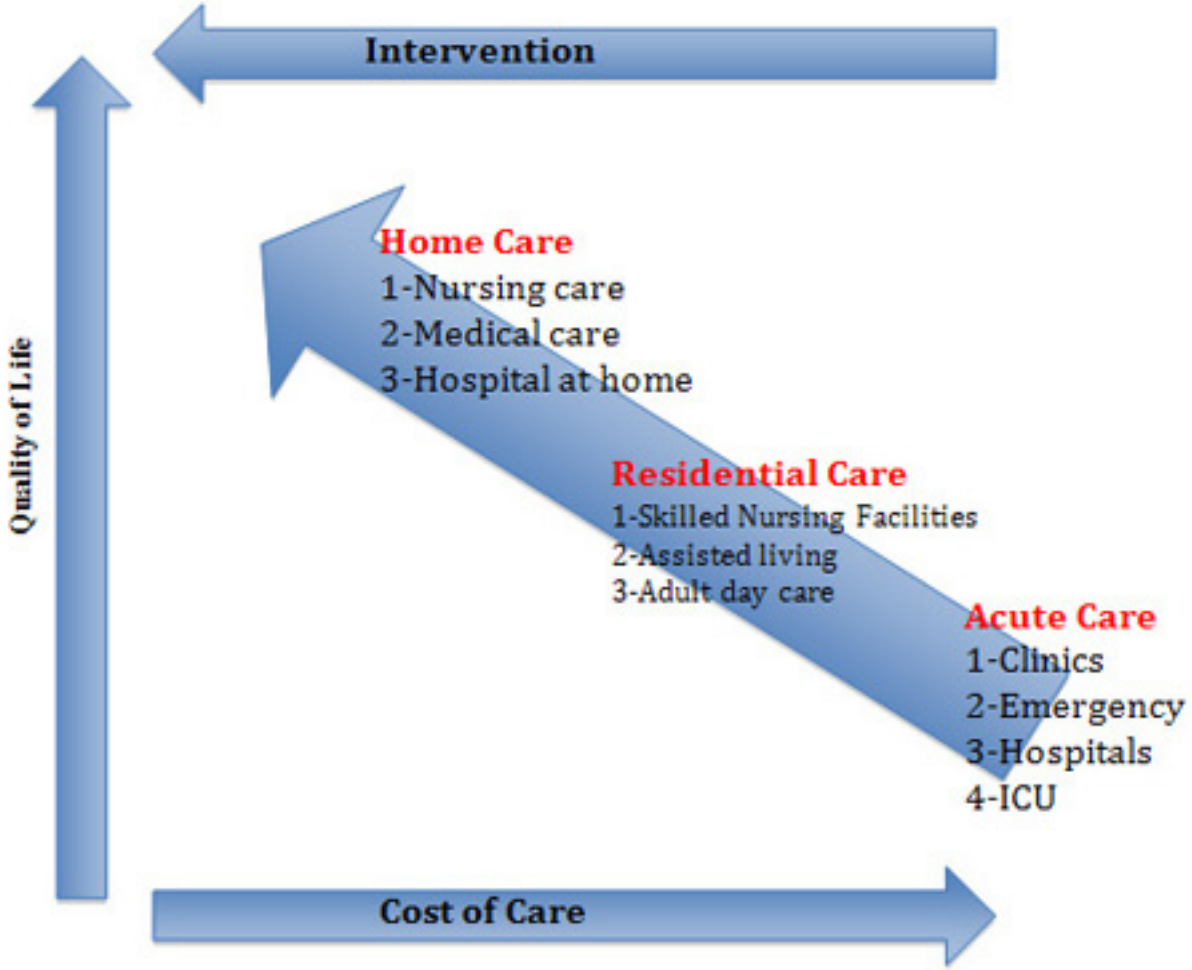
o How can abilities be moved with the goal that individuals can begin performing errands thought to be the domain of the general population on the right of the diagram in Figure 2 (next page), in light of the fact that there won't be sufficient limit on the right?

o How is time moved to the left side in the chart in Figure 2with the goal that preventive care and essential care should be possible to constrain individuals to right side of the graph from constantly happening?

Health care needs to move also from a health service module to an individual wellbeing model. Later on, the health services system won't be maintainable, unless it has a proper framework. Patients who understand that their clinicians may have different backgrounds and motives seek second, third, fourth, and fifth opinions.

The second necessity, is for all the different body parts and frameworks and for all the cell level understandings to be reintegrated into entire individual care. Despite the fact that the advancement of specialty care has been critical in giving a comprehension of the science behind wellbeing and disease, experts may turn out to be unexpectedly one-sided by the medications they prescribe.. Patients who comprehend that their clinicians may have distinctive foundations and thought processes may look for second, third, fourth, and fifth opinions.

Figure 2: Intel strategy for innovation: shifts in place, skills, and time from the mainframe model to the personal health model



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The use of huge information examination to cases information may create more hearty hazard appraisals at the population level yet may not illuminate the decisions of an individual patient.

Mainstay of Personal Health

Care customization manages the shift from population-based to person- based treatment. Although that includes personalization based on genomics. Early experiments demonstrated that consistent positive behavior change is possible, as long as clinicians communicate with people in the way in which they prefer.

A few movements of the health services framework that would shore up the three pillars are required. A few cases incorporate the accompanying:

o Moving from expert care to more self-care.

Frail elderly: These can give self-care if the advancements are usable and the advantages (the incentivized offer) to them are clear. Regardless of the possibility that lone 20 percent of patients can use self-care, it would move the needle on cost, quality, and access. That 20 percent of patients would be the great early adopters, and after some time, more individuals will have the capacity to move toward self-care undertakings.

o Moving from exchange based care to care coordination. Programming apparatuses can encourage such a move by supporting groups, as said above, and giving status reports progressively.

o Moving from " medical-ized" records to "life-ized " ones. Information that is more extensive than the information that is generally important to the medical group should be incorporated into the records for the patient, despite the fact that whether that information will be incorporated into various information frameworks or somehow consolidated into a solitary framework still can't seem to be resolved.

"We need to escape this attitude that all that we have to do should be costly. They likewise may turn out to be

progressively not so much costly but rather more broadly accessible.

Principles for the Evolution of Health Care

Instead of an emphasis on technology, it is ecommended to follow a number of principles that will encourage the advancement of health services and the already portrayed "move to the left" (see Figure2):

" Move the place of care to the minimum prohibitive setting.

" Shift abilities to patients and parental figures.

" Shift the time of care so it is proactive and not receptive.

" Shift installments from individual suppliers to groups of suppliers of care and move installments so that results that mirror the utilization of a all encompassing methodology are accomplished.

The beginning stage for these progressions, is the social covenant that declares, "We as a culture have concluded this is the manner by which we're going to set ourselves up for individuals who require care and the individuals who give it."

Home Health Care Under Medicare and Medicaid

Currently home health services, the ordinary storehouses of Medicare and Medicaid do occasionally cooperate and cover, however they are not really incorporated.

Medicare is an entitlement program that covers Americans aged 65 years and older and people under age 65 years with permanent disabilities in a uniform way across the country. Medicaid, by definition, is more complicated because of the combination of federal requirements and the different eligibility and benefit rules of each of the 50 states. The low-income people who are eligible for Medicaid and who receive home health care services often are also covered under Medicare (and are referred to as dually eligible), which is their primary coverage.

Home-based services (including nursing services; home health aides; and supplies, appliances, and equipment) are obligatory benefits under Medicaid, but the more extensive cluster of home-and group based administrations is optional. Even in this way, states may force restrains on their Medicaid home health services programs. Five US states have put restraints on program expenses, and 25 states and the District of Columbia limit benefit hours. The advantage is commonly secured under fee-for-service arrangements, albeit many states are moving toward the utilization of capitation. As in Medicare's home medical services program, a doctor needs to give a written arrangement of care to beneficiaries to be qualified for Home health care services.

Obligatory advantages for people who meet all requirements for Medicaid home medical services incorporate low maintenance or irregular visits by a registered nurse; home helper services by credentialed specialists utilized by participating home health agencies; and fitting therapeutic hardware, supplies, and apparatuses. Physical, occupational, and speech therapy in addition to audiology services are discretionary advantages. Fifteen state Medicaid programs permit beneficiaries to mastermind their own particular services, including providing installment to family parental figures. These self-coordinated administrations programs have for the most part demonstrated fruitful in diminishing neglected patient needs and enhancing wellbeing results, personal satisfaction, and beneficiary fulfillment at a cost comparable to that of customary home health agency-directed service programs.

In the customary Medicare program, which utilizes fee-for-service payments, it has been generally simple to track how much that open protection pays for different sorts of services, including home medical services. Be that as it may, as expanding numbers of Medicare and Medicaid beneficiaries are moving into capitated plans, estimation of the quantity of individuals receiving services, the amount they are getting, and what government source is paying for these services gets to be distinctly harder. Under fee-for-service programs, Medicare right now pays the biggest share of home medical services uses (44 percent), even with its generally contract qualification criteria, trailed by Medicaid (38 percent) Private coverage and other outsider payers pay around 10 percent, and another 8 percent is paid out-of-pocket. The measure of out-of-pocket spending is most likely downplayed, in light of the fact that no solid methods for catching this information exists.

Home medical services remain a generally little bit of aggregate Medicare and Medicaid spending.

Who Is Served?

Around 66% of all Medicare home health services clients have at least four or more chronic conditions or if nothing else, one functional disability. People receiving home medical services are regularly physically compromised and cognitively affected. These are individuals with numerous difficulties. Although the majority of these difficulties emerge with regards to ageing, they likewise confront the number of inhabitants in individuals with handicaps secured by Medicare.

Home health care utilization by and large, the quantity of home medical services visits per client, and Medicare spending per client all ascent with age, as does the utilization of numerous other health care services, including inpatient care, talented nursing care, and doctor services, and the utilization of a few medications (yet not hospice care). The age-per capita spending curve for each of these services has a peak. For instance,

doctor services and outpatient drug spending top at age 83 years, declining from that point, and that after age 89 years, hospital expenditure uses begin to drop. Spending on home health services does not peak until age 96 years, and spending on skilled nursing facilities tops at age 98 years.

Albeit just 9 percent of the conventional (i.e., non-managed care) Medicare population gets home medical services benefits, the health services spending for these people represents 38 percent of customary Medicare spending. Some questions about these patterns of care:

o Are recipients receiving care in the most fitting setting?

o Are they receiving great quality care in?

o Does this pattern of care ideally adjust government, state, and family spending plans?

o How will the country fund care to an aging population?

In general, the utilization of Home health care services has expanded as of late, reflecting both a maturing population and the ascent in the occurrence of chronic conditions noted before. In any case, spending on home medical services, which had been rising correspondingly, has leveled off as of late, despite the fact that home health services serves more individuals. This might be expected to some extent to installment decreases from the Patient Protection and Affordable Care Act of 2010 (ACA)2 and more prominent late endeavors to address extortion in a few pockets of the nation.

Trends in Public Policy in the United States

On a very basic level unsustainable health services cost direction that the USA is on, Federal spending shortfalls will develop in respect to the GDP, and in 10 years, intrigue installments are anticipated to be bigger than the U.S. Department of Defense spending plan, creating a tight cash condition.

At the focal point of these troubles, are the projects that compensation 80 percent of the home health services charges: Medicare and Medicaid. Medicare is spending its assets quicker than finance charges and premiums are recharging them and will go under expanding monetary pressure. Medicaid faces comparative pressure, particularly at the state level.

The home health services industry's money related condition looks particularly problematic, with somewhere in the range of 40 percent of Home health care suppliers anticipated that would be in the red in only a couple of years. Besides, new U.S. Department of Labor standards commanding extra minutes pay for specialists not previously getting it will help office costs, if and when they go live. In the home, LTSS have been given by relatives, however later on, this wellspring of care will be less accessible, in light of the fact that relatives will work.

In spite of this mix of weights, openings likewise exist. Keeping frail older people with chronic diseases and inabilities out of intense care could spare a considerable measure of cash, so "the open door at the front end to truly take care of the Medicare cost issue is a genuine one." Research additionally recommends that home health services can play a significant cost-sparing part in post-acute care also. To exploit such open doors, the home medical services part will be required to record their cost investment funds as well as the nature of the care that they give. The blend of lower cost and excellent makes a strategic offer for policy makers and citizens. Advance, the customary division between healthcare services and LTSS needs to end.

The current problem is the fact that policy makers are attempting to settle these programs at the edges," when what is required is "a central reconsidering of how we convey every one of these services."

Albeit innovative advances have settled a substantial number of significant policy issues, it is not clear what such progress would be. For instance, what organization will affirm new health technologies devices? Are medical services applications going to be regulated by the U.S. Food and Drug Administration (FDA) or by the Federal Communications Commission? At the point when an administration crosses state lines (as with telehealth), challenges with state-based permitting and extent of practice controls may emerge.

Trends in the Real World

A few patterns help depict the truth of U.S. home health care

" Restrictions in the Design of the Medicare Home

" Health care Social Benefit for Today's Population

A great many people are ignorant of Home health care services until a snapshot of emergency, when a staff member from the hospital, inpatient rehabilitation center, or nursing home exhorts them that their cherished one is being discharged and courses of action for care in the home should be made. A great many Medicare recipients who are older or have handicaps and their families have needed to face this emergency and are accepting home services, however the advantage is a poor fit to their requirements. Composed right around 50 years prior, the Home health care advantage underlines recuperation from intense sickness and the open door for wellbeing change, and it presumes that the recipient's issues will end. It doesn't underline wellness or prevention , and it doesn't pay for solace care or palliation toward the finish of life.

Patients getting Medicare Home health care services must be home-bound, and once they are no longer kept at home, the advantage closes. Be that as it may, "unending

malady goes on, [and] pharmaceuticals keep on coming into the house,". By then, Home health care suppliers have nobody to hand the patient over to or move to for ongoing care and coordination. Understanding focused medical homes take care of this issue, however they are a long way from all inclusive.

Overseeing Continuous Transitions

In spite of these difficulties, Home health care is being rehashed to fill in as a vital piece in the continuum of perpetual care. In responsible care associations, with their capitated structure, a few suppliers are working around the strictures of the Medicare home medical services advantage and ensuring that patients get the required administrations. Moves not just between care settings-particularly healing center to home-additionally amid the timeframe after a doctor's visit are times when patients unquestionably require help, even with an issue as essential as correspondence.

Despite these challenges, home health care is being reinvented to serve as an important piece in the continuum of chronic care. In accountable care organizations, with their capitated structure, some providers are working around the strictures of the Medicare home health care benefit and ensuring that patients receive the needed services. Transitions not only between care settings-especially hospital to home-but also during the period of time after a physician's visit are times when patients definitely need help, even with an issue as basic as communication.

The home medical services nurse can sit with the patient and relative or other parental figure and audit drugs, measurement plans, and other therapeutic directions to help the family get organized about the patient's health services needs. The truth of wellbeing [care] in the house is the truth of the kitchen table. That is the place wellbeing choices are made, and that is the place wellbeing is overseen," The best quality level of solution reconciliation occurs at the kitchen table.

The most run of the mill issues, are

o Remembering to take pharmaceuticals,

o Knowing what the symptoms of the problems and when and from whom to look for assistance,

o Verifying that the individual or family member(s) make an appointment with the community doctor inside 1 to 2 weeks post-release and that the individual has transportation,

o Making beyond any doubt that solid plans for meal readiness are set up, and

o Checking the patient's capacity to perform ADLs securely or whether courses of action are expected to make these exercises less demanding or more secure so that the individual can remain at home.

It is important to keep individuals connected with every day?" Taking consideration of these critical measurements of care will be essential to every patient and family well past the 30 or 60 days of Medicare's home medical services advantage or a post-acute care benefit.

Conclusion

There are a number of obstacles to synergistic work in home medical services that should be overcome. For instance, doctors assess pain differently from physical specialists, in contrast so do the home wellbeing organization work force. Nor do these three groups evaluate reliance in ADLs similarly, making it more difficult to assess change or improvement. Besides, there is a requirement for minimal basic common language for the outcome measures.

Joint effort is an element of the programs for dually qualified people, in which the objective is better programmatic coordination all through the continuum of care. This is to be accomplished through the integration and arrangement of government Medicare and state Medicaid reserves into a solitary source of monetary support for social and additionally medical necessities.

Home health services does not imply that a person is dependably in the home. It might mean having a cell phone application that reminds a person to take medication; it might be the accessibility of an attendant or pharmacist through email or the phone. Responsive psychologically proper and age-suitable correspondence frameworks would help stay away from pointless police calls.

This work includes more than overseeing ailment; it implies taking a wellness, preventive, and habilitation approach. The idea of home health care is the fact that we may not be able to offer full rehabilitation to the patient, but we can help them live better in their home. This is what we have to remember about the beauty of home care: it's at home.

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