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UDC: 616-053.9-082

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Master's Thesis

TREATMENT AND CARE OF HOME ELDERLY CARE AS AN ALTERNATIVE TO INSTITUTIONAL HOSPITALIZATION

MASTER OF NURSING

Master of Science in Nursing

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Ternopil – 2022

Abstract

Its well-known fact that society must provide its citizen with a safe and dignified old age by ensuring their health and well-being. This can be achieved by creating conditions conducive to the individual development of the elderly, by creating conditions for the adaptation of elderly and their active participation every day's life.

Purpose of this study is detecting the particularities of providing the elderly medical home care as an alternative to their hospitalization in institutions for long-term treatment. The principles of organizing elderly home care with various chronic diseases and conditions which require medical and social assistance were also studied. To provide this investigation was provided scientific literature analysis, study of anamnesis of illness and life, observation of the state of health of patients, methods of general clinical examination of a patient.

This study analyzed and examined the peculiarities of organizing home medical care for the elderly as an alternative to hospitalization. It revealed that to achieve an appropriate balance between care in inpatient social service institutions and other, less intensive types of care, requires a compromise between improving the quality of life and potentially improving the efficiency of services. As result of this scientific research were made conclusions: the features of the organization of medical home care for the elderly as an alternative to their hospitalization were studied, among which it was revealed that achieving an appropriate balance between care in stationary social service institutions and other, less intensive types of care requires a compromise between improving the quality of life and potentially improving the efficiency of services. The most common reasons for organizing care and medical care at home have been investigated. The most common causes of hospitalization in medical institutions of the elderly who are on medical care at home have been studied. The principles for determining the conditions for providing assistance to the elderly have been studied. Possible incentives for persons providing continuous informal assistance and care have been explored. The features of the aging process and improving the quality of life of the elderly have been studied. The quality of life of the elderly should contribute to the desire and ability of a person to lead an active lifestyle and longevity.

CONTENTS

INTRODUCTION

Relevance of the research.

In the decade ending in 12/31/2006, most European countries saw a significant increase in the demographic ratio of elderly and senile people [1, 45, 47]. In the 25 countries of the European Union, this ratio increased from 22.7% to 25.3% and is expected to continue to grow [12, 16, 22]. At the same time, there has been an increase in costs [6, 8, 13, 21, 46] and the use of long-term care of elderly [3, 7, 20, 45] in all European countries [15, 16, 20] Experts forecast this growth to continue exponentially.

These trends have generated interest in the existing forms and sustainability of service provisions [7, 10]. Projected demand and cost indicators for long-term care [5, 15, 45], and future treatment of age-related chronic diseases [37, 43] are significant for the ongoing debate about the best way to finance and serve elderly.

Geriatric medical care is a specialized long-term medical, social and psychological care for elderly and senile patients [12, 16, 20, 22, 26]. These patients are suffering from chronic disabling diseases [28, 37, 41] with partial or complete loss of the ability to self-care. Such care is crucial in order to prolong active longevity and improve the quality of life in old and senile age [28, 30, 31, 34, 42].

A civilized society must provide its citizen with a safe and dignified old age by ensuring their health and well-being. This can be achieved by creating conditions conducive to the individual development of the elderly, by creating conditions for the adaptation of elderly and their active participation every day's life.

Following are major features of geriatric care:

- Organization of medical care for age-related diseases, taking into account their mutual influence
- Long-term and continuous nature of geriatric care provided to the patient on the territory of residence, in the hospital and at home [1, 11, 17, 29]
- Partial replacement of purely medical emergency interventions based on the widespread use of drugs with a combination of medical, social and psychological components

- Close interaction of geriatric service units with other health care institutions and with social service organizations.

Elderly home care and assistance have recently become of great importance.

Most developed countries promote home health care to reduce the growing volume of acute care and inpatient health care facilities such as nursing homes and long-term care facilities for the elderly.

Purpose of the study.

To study the particularities of providing the elderly medical home care as an alternative to their hospitalization in institutions for long-term treatment.

Research tasks:

1. To study the specifics of organizing medical home care as an alternative to their hospitalization
2. Investigate the most common reasons for organizing home health care
3. Investigate the most common causes of elderly hospitalization
4. Examine the principles for determining the conditions for providing care to elderly
5. Explore possible incentives for providers of continuous informal care and assistance
6. Investigate the features of the aging processes and improve the general quality of life

Subjects

The elderly with various chronic diseases and conditions in need of medical and social nursing care at home.

Methods

The principles of organizing elderly home care with various chronic diseases and conditions which require medical and social assistance.

Scope

- Scientific literature analysis
- Methods of general clinical examination of a patient
- Study of anamnesis of illness and life
- Observation of the state of health of patients
- Analytical method
- Statistical research methods.

Theoretical and practical value of the research.

This study analyzed and examined the peculiarities of organizing home medical care for the elderly as an alternative to hospitalization. It revealed that to achieve an appropriate balance between care in inpatient social service institutions and other, less intensive types of care, requires a compromise between improving the quality of life and potentially improving the efficiency of services. As a result of this study, the most common reasons for organizing care and health care at home have been investigated:

- The most common reasons for hospitalization in medical institutions for the elderly who were receiving medical care at home
- The principles for determining the conditions for the provision of assistance to the elderly have been defined
- Possible incentives for providers of continuous informal care and assistance
- Features of aging processes and improving the quality of life of the elderly have been investigated

The quality of life of the elderly should contribute to their longevity, and desire and ability to maintain an active lifestyle.

CHAPTER 1
ORGANIZATION OF HOME MEDICAL CARE FOR AS AN ALTERNATIVE TO HOSPITALIZATION
(LITERATURE REVIEW)

Continuity of care is a key element of primary health care [7] associated with improving health outcomes [12, 20, 26]. Hospitalizations for conditions [7] requiring inpatient care can be prevented in a significant number of cases if these conditions are identified in timely manner and well managed in primary health or home care [2, 40, 50]. Ongoing monitoring of patients, as well as the time required to determine the proper course of care are also significant factors of such care.

When examining the relationship between hospitalizations [7] and continuity of care, most studies (93.3%) demonstrated a statistically significant relationship between higher levels of continuous care in outpatient settings and a reduced likelihood of hospitalization [7]. There was a strong association between studies on patients with certain diseases [7, 24, 28, 31, 32, 37, 41, 43].

Data analysis has shown that an increase in the number of organizations for the elderly of continuous medical care on an outpatient basis is associated with a smaller number of hospitalizations for various diseases and the need to care [7].

All European countries expect an unprecedented increase in spending on formal and informal types of social assistance [23, 25, 48], as well as an increase in their use, due to the increase in the number of elderly people dependent on such assistance suffering from long-term chronic diseases.

The future increase in the financial burden of services for the provision of assistance to the elderly requires the optimization of resources and conditions for the provision of care [8, 21, 46]. It also takes into account and meets the needs of both individuals and communities.

The projected decline in the supply of informal care will require investment in home-based self-help programs and in support activities for home-based caregivers.

The projected increase in the use of home care and residential social services can be partially offset by investing in home health care and other alternatives to home care and assistance [16, 23, 25, 48].

Social policies that promote independence and protect people with common chronic diseases from worsening conditions can be an effective tool in containing costs, promoting health and well-being.

The issues can be summarized as follows:

• Planning for care and assistance requires more sophisticated planning processes [13, 19], assessing population needs, resource allocation and response to care needs.

• The criteria used to determine eligibility for services and support should account for individual needs and be tied to a single system of interaction of service providers, focused on the client.

The development of a service delivery mechanism includes:

• Individual needs should be assessed according to a single coordinated scheme using a comprehensive interdisciplinary approach [11, 13, 14, 17, 29]. There are advantages to combining an individual needs assessment using broader (national) eligibility criteria.

• Individualized care planning should help services better match needs and can limit cost increases [8, 21]. Information centers at the locations of accessible services will support elderly, caregivers and home helpers to make effective use of the service package.

It is imperative to create a client-oriented financial mechanisms to ensure smooth functioning of these mechanisms such as:

• Payments made by the consumer make it possible to personalize the services for the provision of assistance and care; however, consumers also need the support of structures to help make the best decision and provide support to care givers.

• It is crucial to officially recognize the benefit of informal assistance [23, 45, 48] and to provide support through investment and aid to care caregivers.

Informal care and care for the elderly requires various incentives, in particular:

• Fragmented and ad hoc care should be replaced with integrated and coordinated action across the provider system. A personalized plan of providing care and assistance should be established during the assessment. Funding and appropriate processes would encourage the integration of service delivery across the network of providers.

An effective combination of organizational, financial and practical mechanisms is crucial to achieve an optimal balance between institutional care (in nursing homes and other similar institutions), home care [18, 24, 27] and community-based assistance for target population. This encompasses both health and social care as well as coordination required to account for both the preferences of elderly [1, 40, 44, 47], their families and friends, and the limited resources available to support and fund services.

In Europe, the conditions for providing long-term care and assistance for the elderly as well as the actual definition of "elderly" vary widely.

It is crucial to create a balance of the three main components of long-term assistance and care:

- Home help services
- Institutional care (formal and informal sectors)
- Informal help - help and care provided by family and friends [35, 36, 40].

There is an obvious trend towards increased spending and use of long-term care, an aging population, prevalence of aging-related chronic diseases, and demographic pressure (rising dependency rates) that has catalyzed proposals to revise funding, organization and delivery of affordable, efficient and equitable health and social care assistance.

Data collected from 25 European countries show that over the next 50 years the number of elderly and senile dependents who will require long-term care will increase significantly [15, 45]. Although the prevention and treatment of chronic diseases will reduce the frequency of use of services and the level of dependence on care [24, 32, 37, 43], the burden on health and social services will continue to increase. This is associated with certain risks for patients and medical staff [4, 10]. Therefore, in addition to the need to promote healthy lifestyles [28, 42] and healthy physiological aging, it is possible to draw a number of conclusions that are important for the policy:

• The projected decline in the provision of elderly informal care will increase the demand for services of home care and in residential institutions of social services. This points to the need to develop self-help strategies and home-based services to support elderly and their quality of life [12, 30, 31, 34, 42].

• The projected increase in the number of elderly and senile dependents with chronic conditions [37, 41, 43], as well as the resulting need for formal care, will require an urgent expansion of the range of non-inpatient services such as home care, day care and temporary (supportive) help.

• Limited resources will mean that effective delivery of care will become increasingly important and will require services to be more tailored to the needs of the recipient [8, 21].

• The historical form of fragmented and ad hoc care delivery needs to be replaced by comprehensive and coordinated long-term care, which must be delivered by a system that brings together a wide range of service providers.

• Decision-makers need to plan ahead for technological advances that are changing the direction and context of care.

• Those responsible for developing programs [40] should be made aware of the uncertainty in assessing needs for services based on morbidity trends [24, 28, 37, 43] and lifestyle changes[12, 28, 42], which will influence future use patterns of long-term care.

Achieving an appropriate balance between inpatient social care and other less intensive care requires a trade-off between improving the quality of life [31, 34, 42] and the potential for improving service efficiency. If an elderly person needs minor help, then it is likely that providing it at home will be more conducive to improving their health rather than similar care in an inpatient setting. Once a person's need for assistance and care surpasses a certain limit, then, for reasons of service efficiency and quality of life, both the beneficiary as well as family and friends are more likely to lean towards inpatient care. This threshold depends on the life circumstances of the recipient, their caregivers and access to service providers. Thus, the appropriate assistance and care will differ depending on the characteristics of the population,

As civilized societies strive to make the best use of the scarce resources, care settings (or locations) need to match the optimal provision of services to meet the needs of elderly [25, 26].

Achieving an optimal balance between assistance to the elderly in stationary social service institutions, at home or at the place of residence requires an effective combination of organizational and financial mechanisms, as well as mechanisms for actually serving these target groups.

There are three aspects to the provision of assistance and care for the elderly:

1. Medical and social care
2. Preventive, curative and health-supporting care (within the framework of medical care)
3. Formal and informal assistance (within the framework of social assistance)

A healthcare worker who organizes the provision of medical care [2, 4, 18, 38, 39, 41, 49, 50] needs to clearly know and be able to determine the place or institution where care should be provided to the elderly.

The conditions or locations of elderly long-term care (and how they are defined) vary widely across Europe.

They can be, generally, characterized in three main areas:

Elderly provide for themselves with informal help (from family members or friends who live nearby). In the vast majority of cases, this assistance (mostly basic social assistance, such as eating, washing, dressing, and providing emotional support) is provided on an informal basis [23, 25, 48].

Informal assistance is not professional and is usually not compensated financially. However, countries have come to realize that informal caregivers need special support, advice and training to provide effectively care. In fact, much of what falls under the definition of paid home care is often provided to support, rather than replace, informal care.

Assistance for elderly living at home takes many forms, but in general it can be divided into assistance provided directly at home (for example, temporary assistance during the absence of a guardian) and assistance provided in institutions located close to home (

e.g. in a residential facility and/or in a day hospital). Home assistance and care is usually provided by paid medical or social workers (either in the private or public sector) as part of community care. This type of assistance and care is widely used to maintain the independence of the elderly and to prevent health deterioration (continuous care) [11, 17, 27, 29], but, in addition, can include post-hospitalization assistance.

Medico-social care is characterized by provision of continuous long-term care at the place of residence or in an institution and is aimed at maintaining health. The boundaries between the various traditional health and social care institutions and home care are blurred. New forms of housing, such as "extra care housing", are effective hybrids between assistance and health care facilities, illustrating where a continuum of care and assistance services can take place.

International differences in delivery systems and definitions of elderly long-term care [15, 16, 20] create significant barriers to the development and interpretation of measures of use and costs of long-term care [6, 8, 46].

This includes definitions of long-term care [3, 5, 15, 20, 45] (including borderline with comprehensive medical care), types of services, as well as various approaches to assessing the needs for assistance and care, assessing the severity of the condition of the elderly and old people [16, 22, 26]. The study of trends in the use of social and health services is also becoming increasingly complex, as data are not collected and provided on a consistent and unified basis. Some countries combine and others separate data related to services providing long-term care for elderly (mainly reflecting social issues related to functional dependence) and data on the use of health care services providing care to elderly with long-term chronic diseases [12, 20, 22].

A comparative analysis of European long-term care policies shows that historical precedent, funding mechanisms and the level of benefits for long-term care and general assistance play a critical role in determining where services are provided. Service models that are not able to withstand projected demographic changes and other aggravating circumstances in terms of either cost or service delivery in the future need to be re-assessed. A study of the future costs of long-term care services was carried out for the European Commission in Germany, Spain, Italy and the United Kingdom [16, 20].

A sharp increase in the use and costs of long-term care is expected (Table 1).

Table 1. Projected percentage increase in the number of elderly, service users and spending between 2000 and 2050 using a standard set of key assumptions

	Germany	Italy	Spain	United Kingdom
Number of people aged 65 and over (% increase)	64	56	76	67
Number of people aged 85 and over (% increase)	168	168	194	152
Dependency number (% increase)	121	107	102	87
Number of users of informal care only (% increase)	119	109	100	72
Number of home care users (% increase)	119	119	99	92
Number of beneficiaries in residential social care institutions (% increase)	127	81	120	111
General expenses (% increase)	437	378	509	392
Total spending as % of GDP (% increase)	168	138	149	112
Total spending as % of GDP in 2050	3.32	2.36	1.62	2.89

Dependent is defined in relation to the ability to engage in routine and/or instrumental activities of daily living.

GDP is gross domestic product.

Although informal care has been seen as the most important source of support for dependent elderly [16, 20, 23, 25, 48], the share of this type of care in total care is likely to decrease in all countries.

The 3 primary reasons for this are:

1. Decrease of the acceptability for the elderly to live together with their children
2. An increased tendency for elderly to live alone
3. A decrease in women's capacity to care for elderly spouses and relatives, with a marked increase in women's employment.

It is assumed that a decrease in the relative share of informal assistance will generate a greater need for formal assistance and thereby increase the cost of long-term assistance [6, 8, 13, 21, 46].

Increasing government funding for home and community care reduces the likelihood of receiving informal care from family members and friends who do not live with the beneficiary [23, 25, 48]. Similar results have been reported in North America, where informal assistance may be less available as formal assistance becomes more accessible, but generally does not disappear altogether. Caregivers may still provide personal assistance out of love and/or sense of duty. The financial implications of substituting informal for formal assistance depend on the context in which formal assistance is provided. It is expected that with a wider use of traditional social services (nursing homes, etc.), the financial consequences will be more significant rather than via home assistance [6, 13, 46]

The fragmented and episodic care provided by different institutions needs to be replaced by a more comprehensive and coordinated long-term care involving a range of providers.

Policy makers [40] need to plan for the potentially uncertain future needs for elderly long-term care for the elderly and those with chronic diseases [3, 5, 15, 20, 45]. Although the trend of adding more old people may increase the need for care, the technological innovations, lifestyle changes, and speed of recovery in the last years of life may alleviate these burdens.

Research suggests that attempts are being made in Europe to reduce the growing volume of assistance and care in residential social care institutions (nursing homes or nursing homes) by promoting home-based or home-based care. There is also the problem of the growing burden placed on the informal caregivers [23, 25, 48], a trend that the predictive models define as unsustainable. Therefore, additional scientific research in the field of such scientific work is relevant for improving assistance and care for the elderly, as well as for improving the conditions and efficiency of medical staff [4, 18].

CHAPTER 2
OBJECT AND METHODS OF INVESTIGATION

The object of the study was the elderly with various chronic diseases and conditions requiring medical and social nursing care at home.

The subject of the study was the principles of organizing home care for the elderly with various chronic diseases and conditions that require medical and social care for the patient.

To carry out the tasks of scientific research, the following methods were used:

- Literature analysis
- General clinical examination of the patient
- Study of the anamnesis of the disease and the life of the patient
- Monitoring the patient's health
- Analytics
- Statistical research

Our study consisted of patient observations and data analysis.

The first part of the study involved 298 elderly who needed assistance and medical care at home. These elderly were divided into 2 groups:

Group 1 - patients unable to self-service - 112 patients - 53 female and 59 male patients.

Group 2 - patients who temporarily or permanently need outside help due to the presence of acute or chronic diseases - 186 patients - 92 female and 94 male patients.

The second part of the study involved 223 elderly who received care and treatment at home, but subsequently required hospitalization (emergency or elective).

We divided the elderly (female and male) of this part of the study into 2 groups:

Group 1 - patients requiring emergency hospitalization - 78 patients - 38 female and 40 male patients.

Group 2 - patients requiring planned hospitalization - 145 patients - 82 female and 63 male patients.

The subsequent parts of this scientific work are based on the analysis of the conditions for providing elderly assistance, the study of incentives for persons providing continuous informal assistance and care for the elderly, the analysis of information on the criteria and factors of the quality of life of the elderly.

CHAPTER 3
RESEARCH OF THE MOST COMMON REASONS REQUIRING HOME CARE AND MEDICAL ASSISTANCE FOR ELDERLY

Elderly often require home care. There can be two sets of reasons for this.

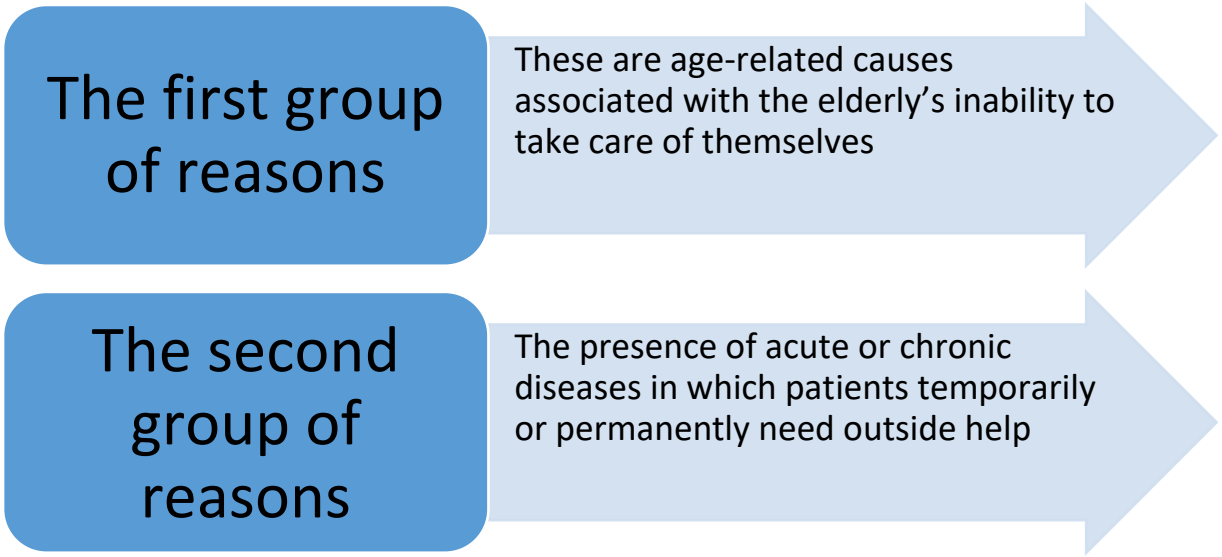

Figure 3.1. The most common reasons for organizing care and medical care for the elderly at home

Elderly or disabled - those who need outside help due to a partial loss of the ability to self-service in the absence of an identifiable disease and those that are prevented from traditional social care are entitled to social and medical care at home.

Social services at home are provided to single elderly citizens and the disabled; elderly citizens and disabled people living alone, whose relatives, due to objective circumstances, cannot take care of them.

A plan of medical and social home care requires a medical institution on the state of health and the absence of contraindications for admission to home care.

Citizens living at home, who are registered with social service departments, are provided with the following types of services:

- Services for the organization of food, life and leisure
- Socio-medical and sanitary-hygienic services

- Services to assist in obtaining education
- Legal services

We analyzed the ratio of the number of the elderly who received home care for the above two groups of reasons:

1. Age-related causes associated with the inability of the elderly to self-care
2. The presence of acute or chronic diseases in which patients temporarily or permanently need outside help.

We divided the elderly of this study (female patient and male patient) into 2 groups:

Group 1 - patients unable to self-service - 112 patients -53 female and 59 male patients.

Group 2 - patients who temporarily or permanently need outside help due to the presence of acute or chronic diseases - 186 patients - 92 female and 94 male patients.

In total, 298 of the elderly who needed assistance and medical care at home participated in this series of studies.

Some of the elderly were denied home health care because they had medical conditions too severe to home health care.

Such conditions include:

- Acute state of mental illness
- Chronic alcoholism
- Virus carrier
- Active form of tuberculosis
- Venereal disease
- Quarantine infectious disease
- Other serious illnesses requiring treatment in a specialized healthcare facility.

In a significant number of observed patients, the major reason for care was the appearance of muscle weakness. One should not attribute the occurrence of rapid fatigue to age, because its cause is most often a serious illness.

There are two types of muscle weakness - local and generalized.

Local weakness does not occur throughout the body, it is associated with a specific group of muscles on the arm, leg and other organs. Its main reasons are:

- Cerebrovascular accidents, such as stroke
- Autoimmune diseases with damage to the nerve fibers of the brain and spinal cord, for example, multiple sclerosis
- Occurrence of tumors
- Dementia (a characteristic sign is weakness in the legs)
- Neuropathies of various etiology and pathogenesis

Generalized weakness can occur due to various reasons:

- Muscle atrophy due to decreased mobility
- Myopathy
- Infectious diseases
- Polyneuropathy (alcoholic, diabetic)

The occurrence of muscle weakness can be triggered by the presence of chronic diseases that nearly all elderly have. One of the most dangerous diseases for the elderly is diabetes - a violation of the patency of blood vessels, the destruction of peripheral nerves, a decrease in the ability of the myocardium to contract. As a result, tissue nutrition is disrupted, oxygen is supplied in insufficient volume and general weakness occurs. Also, such conditions of chronic weakness create further complications of the kidneys, lungs, liver and other internal organs.

CHAPTER 4
REASONS FOR HOSPITALIZATION IN HEALTH INSTITUTIONS OF ELDERLY WHO ARE IN HEALTH SERVICE AT HOME

An examination of the most common reasons for the hospitalization of elderly who were receiving medical care at home.

With medical and home care for the elderly, situations sometimes arose when the patient needed to be urgently hospitalized. This is the action of health care workers or relatives to place a patient in a hospital or a medical institution of private or state ownership.

Types of hospitalization:

- Emergency - if the state of a person's health has deteriorated sharply and there is a serious threat to health or life.
- Planned - if the state of health of a person has deteriorated and the patient needs assistance in a hospital setting with planning the term of admission to the hospital.

Common indications for hospitalization of the elderly who were in home health care are:

1. Presence of absolute indications for emergency and urgent hospitalization (for example, acute appendicitis, gastric bleeding with gastric ulcer, etc.).
2. Cases with an unclear diagnosis in the absence of an opportunity to provide qualified advice, including a condition with no effect from ongoing medical and diagnostic measures, fever for five days or longer, prolonged condition of unclear origins or other conditions requiring additional examination, if it is impossible to establish the cause on an outpatient basis.
3. Presence of obvious indications for planned hospitalization (for example, stomach cancer with indications for planned chemotherapy, etc.).
4. Presence of relative indications for planned hospitalization, combined with the inability to provide the necessary examination and treatment for social conditions on

an outpatient basis, the complexity of treatment and diagnostic process in pre-hospital conditions, the need to connect specialized types of medical care and services (including surgical treatment or rehabilitation) (for example, hernia of the anterior abdominal wall with indications for planned hernioplasty, etc.).

The ratio of female to male patients who needed emergency or planned hospitalization.

We divided the elderly (female and male) into 2 groups:

Group 1 - Patients requiring emergency hospitalization - 78 patients -38 female and 40 male patients.

Group 2 - Patients requiring planned hospitalization - 145 patients - 82 female and 63 male patients.

Among the patients, who received care and treatment at home, a total of 223 of the elderly were hospitalized.

Among these patients, the most common indications for hospitalization were:

Group 1 - patients who needed emergency hospitalization

1. Acute myocardial infarction
2. Stroke
3. Arrhythmia of cardiac activity
4. Kidney failure
5. Liver failure
6. Hyperglycemic coma
7. Hypoglycemic coma
8. Acute inflammation of the joints
9. Acute cholecystitis
10. Acute pancreatitis
11. Acute appendicitis
12. Bleeding from stomach ulcers
13. Fever for five days
14. Prolonged subfebrile condition of unclear etiology

15. Other conditions that require additional examination, if it is impossible to establish the cause on an outpatient basis.

Group 2 - patients who needed planned hospitalization:

1. Chronic heart failure
2. Chronic bronchitis
3. Diabetes mellitus with complications
4. Gastric cancer with indications for elective chemotherapy
5. Hernia of the anterior abdominal wall with indications for elective hernioplasty, etc

Principles of emergency hospitalization.

Emergency inpatient medical care is provided without delay - around the clock and without hindrance to anyone who needs it. Hospitalization for emergency conditions is carried out at the direction of doctors of medical organizations of any form of ownership (including individual entrepreneurs engaged in medical activities), at the direction of paramedics-obstetricians, ambulance teams (medical, paramedical). For this type of assistance, it is required to contact the emergency department of the hospital or an ambulance. In a life-threatening condition, the patient must be admitted as soon as possible to the nearest hospital providing assistance of the required profile.

Scheduled hospitalization - diagnostics and treatment, require round-the-clock medical supervision. This type of hospital treatment may be preceded by an examination by specialists, including the delivery of tests, x-rays, CT, MRI, etc.

Scheduled hospitalization is carried out within the time limits established by the local program of state guarantees for the provision of medical care, but no more than 30 days from the date the attending physician issues a referral for hospitalization (with the exception of high-tech medical care, the terms may be extended).

In the direction issued to the patient, the doctor indicates the date of the planned hospitalization.

In the event of a planned hospitalization of a patient, the volumes and timing of treatment and diagnostic measures are determined after his examination by a doctor on the day of admission in accordance with the approved standards for the provision of medical care, patient management protocols, and the patient's condition.

If it is impossible to comply with the required waiting periods, the patient must be provided with the necessary medical care in other medical organizations.

If the deadlines are violated or if the patient does not know how long to wait, then the patient must immediately contact the employees of the medical insurance organization in which the patient is insured.

Selecting a hospital for planned hospitalization:

With a planned form of hospitalization, the choice of a medical organization is carried out at the direction of the attending physician. However, if several medical organizations providing medical care are involved in this case and take part in the implementation of the territorial program of state guarantees of free medical care for citizens, the attending physician is obliged to inform the patient about which hospitals provide the necessary medical care and provide a referral to the hospital chosen by the patient.

For advice on choosing a hospital, the patient can also contact his insurance company.

The patient has the right to request information about the hospitalization, to be reminded of the right to choose, and to be offered a choice of at least two hospitals. However, ambulatory and emergency stations serve certain areas of settlements. The ambulance doctor has the right to refuse to satisfy the patient's demand for hospitalization in a hospital located on the other side of the city, while there are several hospitals nearby that have departments of the necessary profile.

When a patient is discharged from the hospital to a nursing home or other facility, a short written summary should be sent with the patient and a full copy sent to the receiving facility by email, and the receiving facility should be contacted. Ideally, the physician discharging the patient should contact the physician, nurse, or physician assistant who will be caring for the patient in the new facility. The accompanying report must include complete and accurate information on the following items:

•Mental and functional state of the patient

•Time the patient took their medications for the last time

•List of medicines currently used and their dosage

•Known drug allergies

•Advance directive including resuscitation status

•Family contacts and support status

•Follow-up doctor visits and examinations

•Summaries of hospital care, including copies of relevant tests and procedures

•Names and phone numbers of the nurse and doctor who can provide additional information

A written copy of the patient's medical and social history must accompany the patient during transport and must also be sent by e-mail to the receiving institution in order to avoid information interference.

Effective communication between the facility staff helps ensure continuity of care. For example, the patient's nurse may call the receiving facility for a brief discussion of information shortly before the patient's transfer and call the nurse who will care for the patient after discharge.

CHAPTER 5
PRINCIPLES FOR DETERMINING THE TERMS OF ELDERLY ASSISTANCE.

The elderly, especially the very old, need substantial health care. According to studies conducted in eight countries of the OECD (Organization for Economic Co-operation and Development), between one third and one half of community health care costs are incurred by the elderly.

It is known that age-related chronic diseases are the main burden on nations worldwide, both in terms of costs and use of health services. The main reason for this is the increase in the number of elders who live and cope with one or more long-term chronic diseases. This is reflected in:

- Increase the share of health care and costs associated with the provision of assistance to elderly
- Increase in the share of health care and costs associated with the management of long-term chronic diseases, most of which are due to age
- Increased use of institutional (hospital) care, and the corresponding development of intermediate or home-based alternatives, including supportive self-care

Since the early 1990's one can detect (data permitting) a Europe-wide consistent trend in the use of hospital capacity, namely: intensification of the use of hospital equipment, a decrease in the number of hospital beds and a decrease in the length of stay.

At the same time more patients are admitted to hospitals, and the requirement of care during the time of stay increases significantly. In most cases, this is due to increased pressure on hospital management to reduce costs per patient.

This is due to changes in the nature of provision of assistance to the elderly; it also includes the common practice of early discharge to a nursing facility (such as a boarding house) or home where care is provided by community health and social services.

The main trade-off to be considered is how to strike an appropriate balance between the use of inpatient and other less intensive forms of care on the one hand and improved quality of life and potential efficiency gains on the other.

Home-based assistance and care place the majority of costs on those who receive and provide such assistance and care, while contributing to a higher quality of life than institutional care. This is especially evident in cases where an older person needs less assistance.

As elderly need more help, the difference in quality of life between care provided at home or in residential institutions becomes less significant. Although health care and social care costs rise as the needs of care recipients grow, the relative cost of providing care in the home tends to rise faster than the cost of institutional care. Theoretically, when the difference in costs between home care and residential social service care exceeds the difference in quality of life improvement, then such facilities will be the preferred place of care. As people's need and desire for help and care grows, expectations will rise. Such care in inpatient facilities is an optimally balanced care. Matching the choice of a care site with the individual’s circumstances and needs of beneficiaries and their caregivers enables the best use of the scarce community resources.

The key concepts underlying the entire planning framework were identified and allowed for a three-stage planning framework that combines needs assessment, distribution and individual approach to satisfying the needs of the patient (Fig. 5.1).

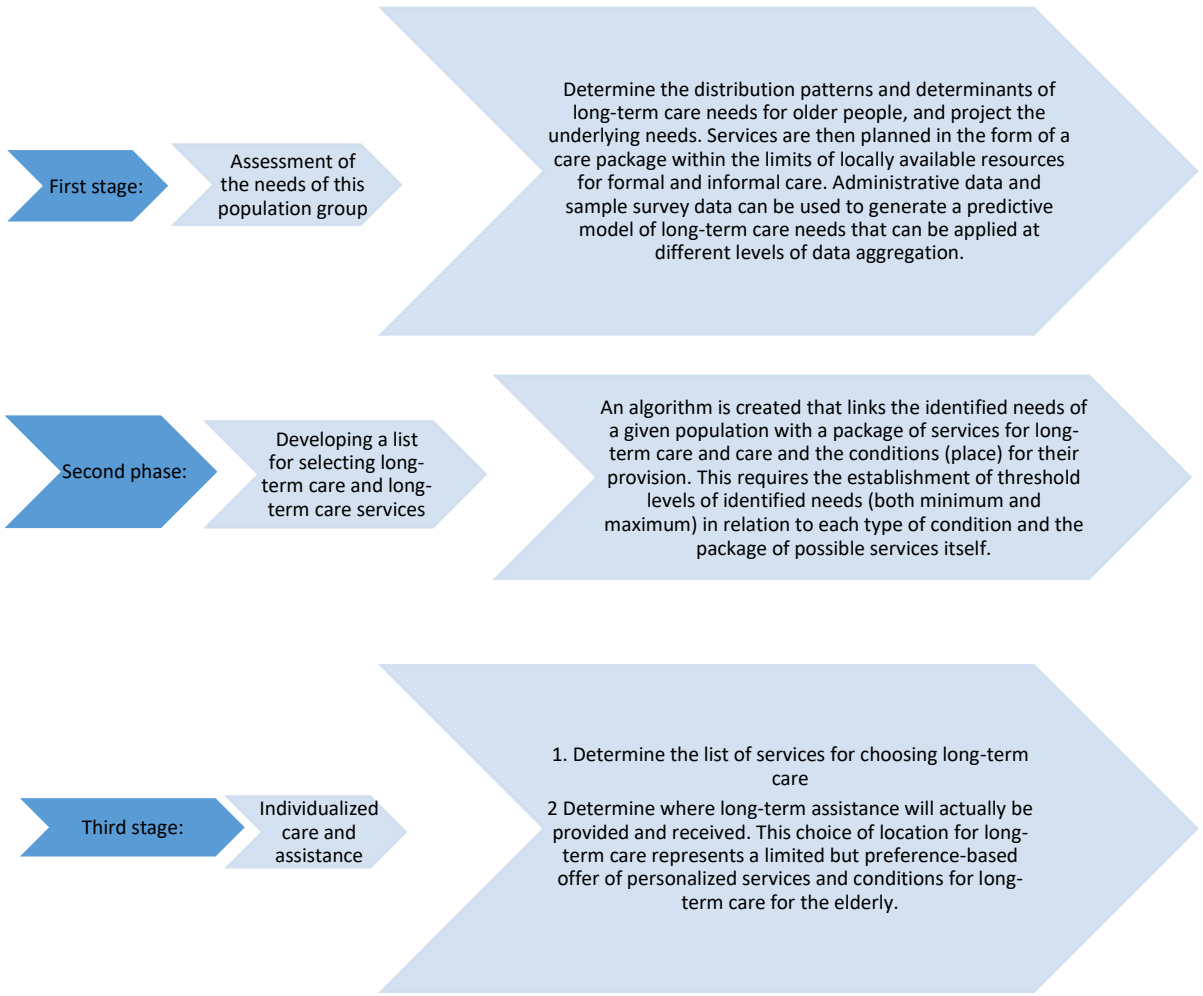

Figure 5.1. Long Term Medical and Social Care Planning Scheme

An important final part of the overall scheme is the generation of information on trends in the use of long-term care, which will further help improve the planning of strategies in the field. Not all countries have data available to populate such planning models, but efforts are needed to prioritize activities to collect such information. This is essential for evidence-based planning of long-term care and assistance.

More integrated approaches to assessing long-term assistance and long-term care needs and eligibility.

There are three important aspects of the operation of national long-term assistance and care systems: service provision, funding and needs assessment. This combination determines whether the problems of an older person meet the criteria for the right to receive

long-term assistance and care, determine the conditions for the provision of assistance and care, and, finally, the quality of their provision. It is impossible to draw a definite conclusion about which combination of these components is most effective. However, there is evidence that future care models should develop a more integrated approach to assessing service needs and providing benefits; it should be tied to a unified system of interaction between institutions providing services included in the list of long-term assistance and care services targeted at a specific client.

Assessment of assistance and care needs and eligibility.

The needs of the individual client are assessed directly affects the fairness, efficiency and sustainability of any particular social system. At the international level, the definition of eligibility and the subsequent procedures for assessing needs and service availability vary widely. Evidence from across Europe and elsewhere shows that there is no simple solution to this issue and that governments face the challenge of compromise. For example, with regard to eligibility for assistance: should long-term publicly funded assistance be provided to all or only to those with low income? What should be the proper balance between national selection criteria (which may be insensitive and inflexible to some needs) and to evaluation of individual needs (which could, potentially, lead to unfair and unequal results).

Both the national eligibility criteria for assistance and the needs-based eligibility criteria have certain strengths and weaknesses. For example, there have been concerns about unfair diagnosis in Germany and Japan, where national eligibility criteria did not adequately reflect the needs of people with dementia. In addition, the use of national eligibility criteria may disadvantage those people whose needs are just above the eligibility thresholds for any given level of aid dependency (as assessed in Germany and Austria). Therefore, additional mechanisms are needed to direct resources directly to people with low levels of need, for which a small amount of additional support can be cost-effective to improve various end results. This may be especially true for the elderly, who may not necessarily have chronic conditions that limit their independence, but whose limited independence remains fragile and in need of supportive care and support.

Therefore, systems based on national eligibility criteria need to be sufficiently flexible and sensitive to the diversity of individual needs. Similarly, countries that prefer

individualized needs assessment (and means testing) may benefit by combining it with broad eligibility criteria that take into account geographic differences in the cost and availability of aid and include an assessment of quality and equity protocols when considering service requirements.

In most countries, the assistance and care needs assessment process provides access to services (and/or a budget to buy them).

There has been a trend in Europe to conduct a comprehensive assessment of medical and social care for the elderly and senile. It should be recognized, however, that since the long-term care needs of the elderly and senile go beyond medical or social care alone, an assessment made by a team of only medical specialists or only specialists in the field of social services affects the nature of the distribution of resources.

A study examining the provision of integrated services for the elderly in nine European countries found that assessing individual needs was a critical step towards achieving effectiveness in providing long-term integrated care for elderly. The study showed the benefits of a single, coordinated assessment that include the following:

• Available resources should not be the basis for needs assessment - first of all, attention should be directed to a comprehensive assessment of the needs of each elderly (demand creates supply)

• The “quality of needs” assessment should be improved to ensure that client needs are met and that equity in eligibility for and access to care is maximized

• The assessment should cover all areas of life and take into account both social and medical aspects; it must be comprehensive and carried out by a multidisciplinary team of specialists

• Professional isolation that impedes a free exchange of information should be kept to a minimum to reduce duplication in assessments and to develop a more coherent package of care and assistance – objectivity and independence should be guaranteed

• Information systems to facilitate the exchange of data on elderly between agencies are essential to ensure a more integrated approach to addressing needs

• Elderly need lawyers to protect and assert their rights to receive assistance, as they usually do not understand needs assessment procedures well - procedures should be clear to clients

• Assessors need to understand the nature and accessibility of local facilities – centralized information points can help people find the services they need (as is the case in France and the Netherlands)

The development of a simple, easy-to-use, multidisciplinary assessment method is probably the preferred approach.

However this is a complex, labor-intensive and time-consuming process that has often failed in countries that have aspired to it.

Furthermore, to ensure that elderly receive (or buy) services in a form that suits their needs, it is desirable to have a single point of access to independent counseling and information. Users should be explained and understand the need for a comprehensive assessment of needs for assistance, and professionals should be able to carry it out.

CHAPTER 6
RESEARCH OF INCENTIVES FOR CONTINUOUS INFORMAL HELP AND CARE PROVIDERS

The services of unpaid caregivers are an important component of supporting the independent living of the elderly. Their participation in service provision is often necessary for aging in a familiar place, but providing such care is often stressful, leading to fatigue and possible withdrawal from the labor market or a reduction in work activity, especially if the responsibilities of caregivers are excessively challenging and complicated.

A key question for future policy is whether the assistance provided by unpaid people will continue to suffice. The following trends in the demand for and availability of informal assistance raise concerns about whether there are enough people who can provide informal assistance.

The increase in the number of the elderly means that the number of young people who can provide assistance and care will decrease.

Those who provide assistance and care are themselves getting older and will need more support in providing services and possibly self-supporting support.

The projected increase in the burden of providing care and assistance will have a severe impact on the mental and physical well-being of free care providers, especially those caring for people with cognitive impairments such as dementia.

More and more elderly people live separately, alone and away from their family; the situation is exacerbated by long distances between family members (and associated travel and time costs) and leads to higher rates of divorce and separation [40–43].

Although most caregivers combine work with their primary caregiving responsibilities and the need to provide care limits the decision to work or not, there is a trend towards greater participation of caregivers, in particular women, in the workforce, especially if they do not live with those for whom they care for. The costs associated with providing informal assistance and care in systems where the costs of materials and equipment must be borne by individuals increase the likelihood of unequal access to quality care services, which will be

determined by socioeconomic status. Entitlement to a range of benefits is the next step in maintaining and retaining a large number of informal caregivers.

Some countries, such as Austria, Germany and Japan, have chosen to address this issue through long-term care and long-term care insurance schemes that provide government cash benefits and support for the functioning of care providers. Compulsory long-term care insurance was introduced in Germany in 1995. Advocates of this innovation hailed it as the fifth and final component of the social safety net, after health insurance, unemployment insurance, pension insurance and accident insurance. Contributions are set as a percentage of income and are provided equally by the employee and the employer. The insurance covers financial incentives, training, welfare and pensions for caregivers, as well as the costs of maintaining and improving home infrastructure. Beneficiaries are financially responsible for services that cost more than compensation payments, but social services pay for these services if they cost too much.

Similarly, compensatory insurance for long-term care and care for the elderly and senile was introduced in Japan in 2000. Today, such assistance is financed through out-of-pocket payments (10%), national and local taxes (45%), and insurance contributions (45%). People aged 65 and over pay a monthly amount based on their income (or pension amount), which varies by local jurisdiction or service. People aged 40-65 pay a certain amount each month jointly with employers through their insurance premiums.

Eligibility is based solely on need, and the system provides formal assistance at appropriate facilities, as well as temporary home care assistance. Insurance mechanisms in Germany are designed to reward caregivers, but there are concerns that the insurance terms do not take into account the growing proportion of elderly, as they are based on a "pay-as-you-go" scheme (payment from current income). If benefits remain uniform, the scheme may become insolvent until benefits are reduced, premiums are raised, or insurance funds are replenished from taxes. Similarly, faced with rising costs, the Japanese government has considered a number of changes, including lowering benefits, raising insurance premiums, or increasing the number of savers.

Historically, in most European countries the social contract assumes that the current (young) generation pays taxes or insurance premiums today in order to finance services for

the elderly, and the next generation will pay into the service financing system for the current generation when they reach retirement age. .

But more important is the fact that the increase in the number of the elderly is changing the nature of the distribution of the population by age groups. As shown by changes in old age dependency ratios, the number of the elderly relative to the number of taxpayers and/or contributors is increasing. Thus, the financial burden that falls on the younger generations, who are forced to pay for the help and care of the older generation, could theoretically become so great that it would lead to a breakdown in the social contract.

Much of the health care has been financed under a "pay-as-you-go" model, in which current income is used to finance the running costs of assistance and care programs for the elderly. The implied rate of return on the contributions people pay when they are young to support the payment of Social Security and Medicare benefits for the elderly and senile was assumed to be the same rate of population growth. This assumes that the population will grow at the same rate and the age distribution will remain the same.

The relatively rapid change in old-age dependency ratios in some high-income countries is causing tensions in governments when discussing future services and quality expectations. Most European countries did not experience a long period of so-called "baby boom", as happened in North America, and therefore, for a longer time, they tried to cope with imbalances in the composition of the population. Germany, like Japan, with high dependency ratios, has introduced a long-term care insurance system as a means of financing current and expected future demand for such services.

However, today's insurance premiums are not sufficient to finance today's consumption of aid due to imbalances in the composition of the population. Consequently, schemes based on the principle of "generational solidarity" may not work in the future. Therefore, most high-income countries will be forced (to varying degrees) to encourage people to take care of providing the health services they may need in the future, rather than relying on taxes to be paid by the next generation.

Australia has already taken active steps in this direction through the introduction of a system of mandatory private pension funds. This may be the main focus of ensuring the long-term sustainability of the provision of long-term care for the elderly.

In a single market, such as in the European Union, there will also be attempts to influence the age bias in the distribution of the population by facilitating cross-border labor migration. An increasing number of young people may be leaving countries with a high burden of social contributions for other countries with lower taxes.

Today's generation of workers, being less taxed than previous generations, may limit the ability of national governments to maintain long-term stable funding from one generation to the next.

The shift in the age distribution of the population also affects the supply of health workers and the availability of informal care providers. Moving towards direct payments to clients in need of health care will allow them to compensate for informal care and assistance services. However, the extent to which assistance and care systems can rely on an existing pool of providers of such services will vary widely from country to country, and their numbers will likely decline. Since the provision of assistance and care in less centralized settings (compared to care provided in nursing homes) may require even more workforce, a lack of capacity among professional workers may also dampen the transition to home and community-based care in the future. Possibly this might result in certain countries relying extensively upon immigration to address this issue. This will mean that poorer countries will become main exporters of such workers.

Another result of this is the possibility that some jurisdictions will rely more heavily on care in nursing homes or assisted living settings. This may be partly due to a shortage of labor, but also to the poor quality of the home environment.

Aging in a habitual place is a laudable goal, but the beneficiary's ability to afford high-quality care at home must be weighed against the ability of governments to fund the infrastructure needed to provide home and community care. This is especially true for emerging economies, such as those in Eastern Europe, where the capacity to finance, plan, and deliver effective long-term care and care services is unlikely to enable policy makers to act on the recommendations of this policy document in the short to medium term. .

Regardless of local circumstances, the trajectory of future actions is, in a sense, already determined. The trends are clear and governments need to be encouraged to act now to

make the best use of all the resources they have: skilled labor, infrastructure, technology and informal care networks.

CHAPTER 7
QUALITY OF LIFE OF AN ELDERLY PERSON

Aging is a long process, starting with a gradual decrease in the functionality of the human body.

With age, there is a loss of psychological flexibility and ability to adapt, interest in the new, the unknown is replaced by the desire for stability and reliability. Awareness of the inevitability of aging, associated with the loss of social status, physical limitations and mental changes, leads elderly to a narrowing of the social circle, a feeling of inferiority and uselessness, and sometimes to severe depressive states.

Psychological portrait of an elderly person.

Research and everyday practice show that there are some characteristic features of the lifestyle and behavior of an elderly person:

- Self-isolation from the social environment as a result of the loss of social fullness of life, limiting the quantity and quality of ties with society
- Loneliness - it is in old age that the loss of friends and relatives occurs, old friends pass away, and children begin to live their own lives, often separately from elderly parents. An elderly person is deprived of the possibility of communication, all possible assistance, constant movement and action
- A decrease in vital interest arises as a result of a lack of social contacts, indifference to oneself and the world around
- Psychological protection that fetters the mind, feelings, vital activity, normally allows a person to gain a temporary peace of mind, but in old age it can be harmful, as it leads to the desire to avoid new information, other life circumstances that are different from the prevailing stereotypes
- Caution, frugality, thrift - as a result of a peculiar sense of time. An elderly person always lives in the present, his past, memories, as well as the future are

always with him, in the present. Certain actions are planned in advance, an elderly person prepares mentally for them

- The inability to perceive the new is due to the fact that elderly are trying to create something akin to a lost paradise from their youth, worrying about and regretting it; concentrating on the past, they do not notice the present, thereby losing the future, cease to develop as a person
- Resentment, irritability, capriciousness, grumpiness, greed, etc. - those negative character traits that were masked in youth, manifest themselves clearly in old age;
- Anxiety and suspiciousness arise as a result of self-doubt
- Negative emotions and depressive states arise as a result of excessive immersion in illness

However, one should not build a psychological portrait of the elderly only because of the negative characteristics of their psychological characteristics. Studies of domestic and foreign scientists testify to the variety of manifestations of the positive attitude of the old person to life and society.

The following favorable socio-psychological types of old age can be distinguished:

- First: Active creative old age. Elderly continue to participate in public life, in educating young people, in providing all possible assistance to those in need - they live a full life, without experiencing any inferiority
- Second: Elderly begin to do things for which they had no time before: self-education, recreation, entertainment, etc. This type of elderly is characterized by good social and psychological adaptability, flexibility, adaptation, but their energy is directed only to “themselves”
- Third: Retired women. They find the main application of their strength is the family, they have no time to be bored. However, as psychologists note, life satisfaction in this group of people is lower than in the first two groups

- Fourth: “Self-carers”. These are retired whose focus is taking care of their health. Various forms of activity and moral satisfaction are connected with this. However, at the same time, there is a tendency to exaggerate their real and imaginary illnesses, increased anxiety

The main factors contributing to aging are:

- Lack of a clear life rhythm
- Narrowing the scope of communication
- Withdrawal from active work
- Empty nest syndrome
- Withdrawal of a person into himself
- Feeling of loneliness
- Feeling of discomfort from a closed space and many other life events and situations

Many of these factors can be prevented or relatively painlessly overcome by changing attitudes towards the aging process in general.

The quality of life of the elderly should contribute to the desire and ability of a person to lead an active lifestyle and longevity. It is formed both with the participation of the state and the person himself:

- Decent pension provision
- Housing conditions must meet the requirements and living conditions of an elderly person, depending on the degree of loss of the ability to self-service
- Accessibility of the environment (public, transport infrastructure, healthcare and social protection institutions, etc.)
- Availability of information
- Protecting the rights of older consumers
- Availability of additional education
- Affordable and high-quality medical and social services
- Healthy lifestyle (rational nutrition, physical and mental activity, psychological and emotional stability)

Criteria for the quality of life of the elderly:

- Satisfaction of needs
- Physical well-being
- Mental well-being
- Social welfare
- Life satisfaction

The feeling of well-being or the feeling of "I'm doing well" is associated with questions such as:

- Housing
- Activity
- Health
- Family relationships
- Meaning of life

Factors that shape the quality of life of the elderly:

- Feeling "I'm fine"
- Meaning of life
- Sense of value

The quality of life of the elderly largely depends on

- Their ability to communicate with others
- Their knowledge of the features of care
- The ability to provide an elderly person with psychological support
- To help organize outdoor activities, work, rational nutrition and equip a home in accordance with the needs of an elderly person.

Those who provide assistance to the elderly must remember that each person's life path is unique and that his past work is worthy of respect. Now helpless and weak - this man in his youth and maturity loved and was loved, studied and worked, raised children. A

person's awareness of his value for the family, relatives and society will prolong his active life, brighten up old age.

CONCLUSIONS

1. The features of the organization of medical home care for the elderly as an alternative to their hospitalization were studied, among which it was revealed that achieving an appropriate balance between care in stationary social service institutions and other, less intensive types of care requires a compromise between improving the quality of life and potentially improving the efficiency of services. .

2. The most common reasons for organizing care and medical care at home have been investigated.

3. The most common causes of hospitalization in medical institutions of the elderly who are on medical care at home have been studied.

4. The principles for determining the conditions for providing assistance to the elderly have been studied.

5. Possible incentives for persons providing continuous informal assistance and care have been explored.

6. The features of the aging process and improving the quality of life of the elderly have been studied. The quality of life of the elderly should contribute to the desire and ability of a person to lead an active lifestyle and longevity.

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