METHODOLOGICAL APPROACH IN THE MANAGEMENT OF HEALTH CARE IN PRIMARY CARE

Pepa Bikova, Galina Chaneva, Maria Dimitrova, Ivanka Stambolova, Dimitrinka Lambreva

Department of "Health Care", Faculty of Public Health, Medical University - Sofia, 8 "Bialo more" Str., Sofia, Bulgaria

Abstract

The goal of treatment of the chronically ill is to maintain a satisfactory long-term good health, to avoid complications by improving the quality of life. The family nurse has a major role in the multidisciplinary team.

The publication presents the results of a study of the weaknesses and gaps in health care for the chronically ill. The disclosure displays a methodology based on international experience to improve the registration system and hence the quality of health care.

Used methods: documentary, survey, statistical data processing and evaluation.

Keywords: *healthcare, nurse, chronic diseases, multidisciplinary team, methodological guidance*

INTRODUCTION

According to the Charter of Patients' Rights "every individual has the right to diagnostic or therapeutic procedures, as fitting as possible to his personal needs", the right to monitor the quality standards and more. (16,17;23) For the realization of these rights, a ratification is needed, as well as series of actions that should be regulated in the laws of each country. A functioning structure is to be created in the community.

In Bulgaria regulations act with different legal force which rule matters related to patients' rights. Under Art. 57, paragraph 1 of the Constitution, the fundamental rights are irrevocable (15;16))

The Constitution defines the relationship between the national and the international law, Article 5, paragraph 4, "the international agreement, which is ratified, promulgated and came into force for the Republic of Bulgaria, are part of the domestic law and take precedence over norms of domestic laws that contradict them." (14;16) International legislation in the area of health insurance and the patient's rights is found in universal international acts like: The Universal Declaration of Human Rights; International Covenant on Economic, Social and Cultural Rights (ratified 1970; entered into force 1976.); and regional european acts: European Social Charter (2000.). (16)

The World Health Organization (WHO) defines chronic conditions as "health problems that require management over a long period of time - from several years to decades." The problem is particularly significant in the context of the demographic reality in Bulgaria, low fertility, high mortality, unemployment, reinforced emigration of young people. The leading cause of morbidity and disability are socially significant diseases, increased survival and life expectancy. People with chronic diseases have reduced quality of life, giving rise to a number of health, economic and social problems. Health care for the chronically ill and the elderly in their homes offers a solution to current for our country, as well as for the European Union, problem. (2;10)

Modern approaches to managing chronic illness report improvements in four areas:

1. Support in the quality of life, in their health status, their satisfaction of the health services, health awareness and the adherence to therapeutic activities.
2. Good system organization that provides health services for chronically ill people - work of interdisciplinary teams. It also provides improvements in the clinical parameters, the work of the specialists to conduct clinical algorithms, greater use of health services.

3. The implementation of the guidelines, evidence-based training workshops and materials improve the behavior of professionals and hence the clinical indicators.
4. The effective interventions in the information system that govern regular audits and feedback (10,172-173)

Achieving a level of "self-management" is not one act process, this is a process that starts with health education in childhood. The health education is an integral process of formation of subjective health culture - knowledge, beliefs and attitudes, health motivation, skills, habits and behavior, i.e. a healthy lifestyle. Understanding of health, according to the Ottawa Charter is a healthy lifestyle and also "mental and social well-being."

The regulated health care reforms of any government have common features and trends that are based on the following main points: a reorientation of hospitals to expansion of the primary health care; integrated approach to the management and the operation of health care; decentralization and regionalization of the medical care and health activities; new approaches to prevention and health promotion; the development of health self-help and mutual assistance; the rapid development of the IT and the application of their achievements in health care; increased attention to quality control and evaluation of the health activities; market orientation of the modern health systems; improvement of the health legislation, development of the health management and improvement of the managerial culture in the healthcare system. (12,13-14)

In the National Health Strategy 2014-2020, the primary care is prioritized in policy 4.3: "Development of the primary care and creating conditions for full and effective use of the potential of the model of general practice and effective coordination with the specialized outpatient care "(SIMP) (24)

The aim of the study is to investigate the status of primary health care, the obligations and rights of the nurses who are working in it, the methods and the instruments for registration of the health services as well as the quality control services.

A methodology based on international experience, tailored to national circumstances in order to align the terminology used in the network, to improve the registration system and hence the control of the quality of health care was created.

Methods that are used: documentary, survey, statistical data processing and expert evaluation.

RESULTS AND DISCUSSION

In medical practice, there are different models of managing the care of chronically ill people. According to Vodenitcharov and Popova, widely used in practice is the model that represents the medical care for the chronically ill in several levels: in the first level patients have relatively mild needs of medical attention. Their chronic condition is under control. The patients are supported for Self-Management (training sessions for patients, consultations with a view to their motivation to participate in healing activities, dissemination of training materials) by a team in outpatient care. This group includes 65-80% of the patients with chronic diseases.

The patients of the second level are regarded as chronic ill people with an increased risk. They need specialized medical care due to the instability of their condition and the possibility of the occurrence of complications.

The third level includes patients with complex needs and high intensity of the planned medical care. They represent about 5% of the chronically ill people. The high risk of worsening of the chronic condition of the patients and the occurrence of complications requires the development of an individual plan for management of the disease. (10;172-173)

In 2014 a survey among 756 people selected randomly outside the hospital environment was conducted. They are from 45 settlements in the Sofia region and their age limit is from 14 to 89 years of both sexes. 54.74% of the respondents are in working age - from 26 to 65 years old. The answers

bring information about many social and economic effects, the micro world of the individual as well as the whole society.

Chart 1 shows the four levels of the stated need of health care for the chronically ill people. More than 65% of the respondents have never received help from a nurse in home health care. Approximately 24% had received at some point help from a nurse and we can classify them at the second level as chronically ill people with increased risk. The respondents most often seek help and advice from general practitioners (GPs) and other health professional - 63.7% ($\chi 2 = 22.828$, $p \leq 0.001$), other patients with similar complaints - 17.9% ($\chi 2 = 13.995$, $p < 0.05$) and 1.9% of the respondents reported that they do not know what to ask ($\chi 2 = 12.395$, $p < 0.05$).

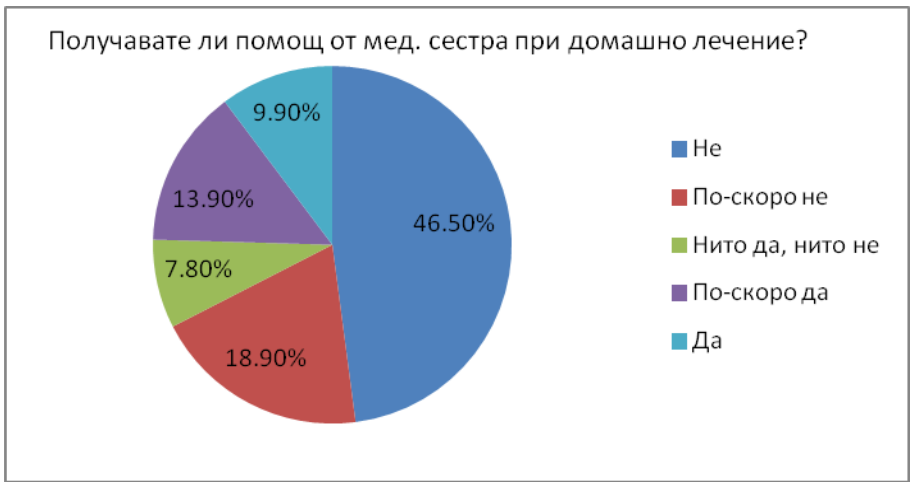


Chart 1 "Provision of health care by a nurse at home treatment"

Regardless of the reduced number of staff and reduced opportunity for contact and communication between the nurse and the patients, approximately 50% of respondents declare a demand for consultation and home visitation from the nurse in case of disease (Chart 2).

The respondents know the work of the nurse and this is illustrated in Chart 2. They would seek her professional knowledge and skills in case of diseases of all systems. The highest demand for specialized services and care are for patients who have no relatives (60%) and are very elderly, and people with chronic diseases - 57%. They are ranked by organ system as follows: diseases of the locomotive system - 40%, the group of oncological diseases - 35%. Very rarely a lack of demand for nurse will be in diseases of allergic nature, the digestive and endocrine systems. These responses illustrate awareness of the respondents, but insufficient information for the types of autoimmune diseases and the possible complications. For exaple, diabetes is a disease of the endocrine system -but we meet it specified in the option "other". The awareness of the respondents is not enough. There is no national system for the selection of a family medical nurse and there is no free market for offering a qualified home care.

The conducted survey shows an increased demand for qualified professionals in the primary care. To meet the legally set trends and plans, it is also needed a training of the nurses to achieve specific health care in the patient's home, in primary care.

Currently the work of the general practitioner is clearly regulated. There is missing regulation for the place and the role of the nurse in the family medicine and outpatient care.

The care for the chronically ill in a home environment is a complex medical and social problem. The care for patients who are treated in a hospital environment, only address the medical problem. Prolonged (chronic) is a disease or health problem that lasts or is expected to last six months or more. This includes diseases that are of a seasonal nature and their manifestation is for a period of less than

six months (e.g. allergic diseases). A main part of the diseases are treated in the outpatient care in the patient's home. Medical special care is given by a multidisciplinary team. According to the need of the patient and his relatives, a visit and care at home can be made by the general practitioner and the graduate nurses, therapists, nurses, social workers, assistants and others. Teamwork is an important skill for every healthcare professional. The lead role in this team is that of the patient, as a partner and as one responsible for their own health. The success of the treatment is a personal success for the efforts made to get a good result. These are diseases in which the body does not function correctly: the function of an organ ,or a whole system, is impaired and this leads to permanent disability. (4;5;6)

When the chronically ill patient receives treatment in a long period of time, or periodically carry out control tests, in order to feel independent, he must be able to orient himself and not be dependent on an expert or other family member or the team. The treatment aims to create the most private and independent individual, even if he or she is one with a severe disease.

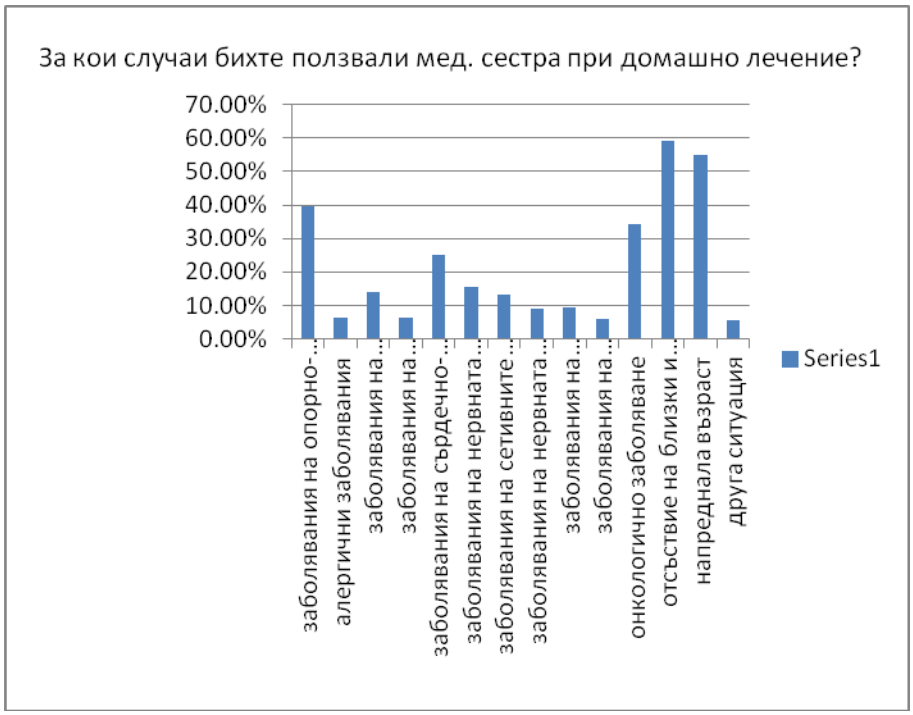


Chart 2 "Then need of nurses in home care"

Through this documentary study we found out that in the Ministry of Labor and Social Policy has created methodological guidelines for the place and the role of social workers. The role of a social worker is, primarily, making an assessment of needs, both in the initial and periodic stages of the plan of care. The main goal of this plan is to improve the social functions of the user. The most popular community services at home are personal assistant, social assistant, home assistant, home care. A methodology for provision of social services is prepared for them. A strategy is made to ensure equal opportunities for people with disabilities 2008-20015.

The needs of people with chronic diseases are not really only medical or only social, they are complex - health and material, psychosocial, spiritual and educational, etc. needs. That's why the services should also be integrated. This requires the work of a multidisciplinary team. Leading place in the team will have this specialist who may be most useful in the particular situation.

The nurses job and duty is to be with the patient- no matter if this person is in the hospital environment or at home. The modern conception of her work is that she is the specialist who must assess the patients health needs. She is a mediator and mentor in the team of experts, patient/user and relatives of

the user. What kind of specialists will be involved in the team depends on the status of the patient. Well organized and conducted health care will improve the health of the consumer/patient, it will allow him to enrich his social life, to become more active, more independent in his social functioning. The efforts of all professionals will improve the quality of life of people with chronic illness and their families.(19;20;21;22)

In the European Union, North America and other countries different regulations that govern the work of the nurse in the patient's home/user, preventing all the team of unacceptable errors are in place. They ensure the quality of care and regulate the financial side of the issue. Currently there is a lack of regulation for the work of nurses in primary care, and particularly in the patient's home. There is a need of elaboration of clear regulations for:

1. The need for specialized training of nurses who are working in the patient's home. If you choose the three-step model of care for chronically ill (aq, pop), nurses must have different skills for each stage of treatment and care. For the first stage - care can be organized and make a nurse specializing in the prevention, diet, health education and training. For the second level of care will require nurses specializing in manipulations, care for wounds and bandages. Care for people with a stoma, oncology patients and other specific, highly specialized manipulation - the third level.
2. Alignment of the terminology used in order to better documentation and reporting activities.
3. Development of technical data sheets. That will allow each process to be validated.
4. Clear definition, elaboration of a regulation that will implement the training function of the nurse.
5. Documentation that meets the needs of all professionals and the user of the service. Variants of documentation are both paper and electronic form, in conformity with the willingness and ability of the user.
6. Single pricelist for any manipulation and service in the outpatient care.
7. Clear regulation of the financial responsibility of the NHIF, the municipalities and the private person.
8. A clear and transparent mechanism for monitoring activities.
9. A clear mechanism for regulating the similarity in the work of nurses and social workers in order to avoid duplication of activities or "regulated" inactivity.
10. Create a network of service providers 'care home' to create a market regulation of prices and quality.

A project for methodological guidance for the provision of "home care" is made in accordance with the requirements of the standards of quality of the medical practice, Regulation № 1 of 8 in February 2011 which regulates the professional activities that nurses, midwives, associated medical professionals and health assistants may perform. Other documents that are used in the elaboration of the project are the Health Insurance Act Article 55, Universal Declaration of Human Rights, European Social Charter and other normative documents. The purpose of the methodology is to provide guidance to the service providers of home care for their quality performance in the practice and to offer all the institutions at local and national level tools for monitoring, regulating and improving its efficiency. The development of the methodology and its application can help create a competitive environment for service providers' "health care at home." The legal regulation of the opportunity of organizing the supply of such services is not enough to implement them. At the time of the study there is a lack of service which could ensure help by a qualified nurse in the patient's/user's home.(37;38;25;9)

The methodology is designed to ensure that the following principles:

- respect for privacy and dignity;
- autonomy and independence of the consumer;
- confidentiality of personal data and information;
- rules and procedures for providing the service "Health care at home";
- assessment of the need of health care;
- Selection and appointment of "family nurse";
- a contract between a supplier and a consumer;
- elaboration of individual healthcare plans;
- assessment of the need and development of individual training plan for the user and his relatives for the acquisition of knowledge and skills to cope with everyday needs;

The methodical approach for provision of health care in primary care include:

- Creating an organizational model
- Establishing an organizational structure
- Implementation of methodological approaches to nursing care, including rules and procedures
- The introduction of documentary and informational support for the patient
- Establishment of an information panel for services management
- To set frames of contractual relations with the financial institutions and patients
- Determination of the ethical frameworks, patient rights and professional responsibilities for health care professionals
- Development of a program of professional training and development of the staff
- Development of a program to assess the quality of services

An expert group of 12 nurses who work in the outpatient care structures, evaluated the described methodology in terms of the opportunities for implementation in terms of the health insurance in the country. All the experts expressed a positive opinion on the applicability of the methodology in the primary care. In the current practice, regardless of the regulation of the independent activities of nurses in the regulations, the nurses can not fulfill them due to lack of contractual relations, and the lack of official financing package of health care to outpatient and home care patients. The experts agree in terms of the comprehensiveness of the methodology, as the performance of independent activities requires a clear and accurate description of health care. According to the professional competence of the nurse, she/he is able to carry out an assessment of the needs of the patient, to produce individual nursing care plans, to carry out alone or with a caregiver and relatives of the patient, and to account for the achievement of the expected results of care. This process determines the management of resources, information and steps in health care.

The experts consider that the methodology fully allows nurses from primary care to provide the patient and family care that they need when it comes to chronic patients, elderly / old / people care for patients in the post-hospitalization, etc. The patients still believe that all of their medical problems need to be carried out in hospital. Modern hospital provides services that require significant financial resources, making it necessary for patients to understand that the stay in the hospital must be extremely short and the healing process could be conducted at home.

According to the expert group the developed a methodology creates many opportunities for nurses to quickly and accurately communicate and coordinate with all actors in the outpatient or home care. It's high time to add the advanced features of information technology in the nursing sector by developing a specialized product The information assurance of the practice is a prerequisite for planning and reporting, and to carry out continuous monitoring. Patients have the need for constant communication and support from the nurse and it is quite possible with the modern communication technologies.

The experts emphasize the contribution of a certain methodology for actual implementation of health care in primary care, which can be evaluated and funded. Under existing conditions even patients to seek professional assistance from nurses, there is no mechanism by which they can prove their business and achieve financial reporting. Therefore, it is essential to change this vicious practice.

CONCLUSIONS

The health reforms conducted in primary care in the country in recent years are incomplete in terms of the opportunities that patients must have for home treatment and care. The lack of such an organization of care will lead to violation of the rights of patients and they are forced to do without professional help and support of health care professionals. On the other hand the legal documentation allows these professionals to carry out independent activities for patients, but there is no model for management of the resources, including the financial one. It is therefore essential to develop methodologies that can be used as a basis in the design and creation of a new model of organization and financing. The professional health care should be carried out only under clear and precise rules and standards, which guarantee the quality of patient services.

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