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Reflections of Providers on Encouraging Elderly People's Daily Mobility

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Abstract

Increasing numbers of older adults mean that effective post-acute home health care is the key to their independence and quality of life. Although caregivers are important in facilitating functional needs of such individuals, their experiences and perceptions are understudied. The objective of the study is to explore how caregivers view managing the activities of daily living, mobility, and self-care in older adults under the care of home health care services that are post-acute in nature. Qualitative interviews and observational approaches helped to emphasize the most important challenges and approaches used by caregivers, such as interaction with healthcare workers, the home environment adjustment, and the tasks allocated to care versus personal well-being. The results indicate that even though the commitment of the caregivers is eminent, they usually encounter emotional, physical, and logistical stress, which influence the quality of care and the health of the caregivers. The knowledge of these perceptions is invaluable in the designing of supportive interventions, educational programs, and policies that increase caregiver competence, confidence, and resiliency, and eventually better patient outcomes in the home health care environment.

Keywords: ***Caregiver perceptions, older adults, functional needs, post-acute care, home health care, daily living activities, caregiver burden, patient-centered care.***

1.Introduction

The healthcare of the aging population has experienced radical change over the last several decades and there is a growing focus on the transitional care models that will provide the continuation between the hospital and home setting. This change is indicative of the demands of the economy to cut down on hospitalizations as well as an increasing awareness that the elderly can tend to recover better in a familiar environment. Nevertheless, this shift presents unprecedented burdens on informal caregivers in general, most often family members, who are left to negotiate complex medical requirements, functional impairments, and care coordination issues with little preparation and with little assistance(1).

Hospital-to-home transitions in elderly people is a pivotal point in the medical care continuum and recovery success is in many cases determined by the ability and capability of informal caregivers. These people, mostly spouses, adult children and other family members are put into the positions that demand medical expertise, physical and emotional strength that can be much more than they have experienced or been trained in. It becomes even more complicated with the older adults who introduce a variety of chronic conditions, cognitive disabilities, and functional dependencies that have to be managed and controlled on a regular basis.

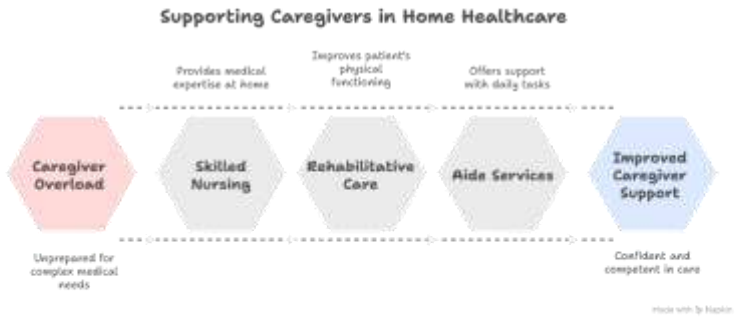

FIGURE 1 Supporting Caregivers

Home health care services in the form of a post-acute care have also become an important aspect of transitional care model as it offers skilled nursing, rehabilitative care, and aide services to older individuals and their caregivers over the vulnerable period after hospitalization(2). These services will provide a special opportunity to the medical care practitioners to evaluate, educate, and guide the caregivers real-time at home. In contrast to the institutional setting where the professional staffs have overall and primary accountability of the patient care, the home health care model functions under the collaborative model where the informal caregivers will have a vital role when it comes to the daily management of care.

The physical functioning requirements of older adults, which include both the basic activities of daily living that include bathing, dressing and mobility and the instrumental activities, which include medication management, meal preparation and household maintenance, are the foundation of the tasks of the caregiver in the post-acute period. Such functional needs tend to worsen after hospitalization because of the deconditioning process, medical complications, or complications exacerbation. Studies have repeatedly shown that hospitalization often leads to functional impairment in older adults, and that develops new or amplified care needs that extends well beyond the acute care episode(3).

Gaining insight into caregiver attitudes toward the management of these functional needs is crucial to the process of designing effective interventions and support methods in the context of the post-acute home health care environment. The caregivers have firsthand information on the preferences, routines and the baseline functioning of the care recipient and this information is invaluable in customizing the care methods. Nevertheless, they also encounter very important issues such as role strain, conflicting roles, social isolation, and insufficient preparation to perform their caregiving roles. Such difficulties are especially sharp in situations related to care transition when uncertainty regarding the prognosis, care needs, and resources available may cause anxiety and be overwhelming.

Even the home setting provides chances and challenges towards a successful care management. Although home has the potential to be comforting and favorable to recovery, homes are not usually constructed to accommodate those with functional limitations, which can pose safety risks or accessibility barriers. Caregivers are forced to continuously make changes to the living environment, purchase adaptive devices, and restructure the domestic schedule to suit the evolving requirements of the care recipient. The environmental adjustments do not only need financial resources but also the awareness of available opportunities and well-constructed execution.

The formality of formal home care services alongside the informality of caregiving makes this a complicated dynamic in which care should be taken. Home health care providers penetrate the personal sphere of the families and witness the close-care dynamics and evaluate the needs of the patient and the caregiver. This connection provides unprecedented education, skill growth, and emotion support opportunities, yet demands a keenness to family dynamics, cultural tastes, and traditional patterns of care. The fleeting characteristics of most post-acute home health care service operations provide the urgency to such interactions since there is a narrow window of opportunity to intervene and educate.

The policies and reimbursement models used in healthcare today focus on fast discharge of patients in acute care facilities and a time-constrained home health care that puts the pressure on the need to gain stability and self-sufficiency within a short period. This setting further strains the caregivers who might not be ready to bear full responsibility over complex care needs after the services of professional providers are withdrawn. The disconnect between caregiver confidence and competence in meeting functional needs may have dire consequences on the care recipient outcomes such as the risk of rehospitalization, functional decline and burnout in the caregiver.

The literature has not explored the experiences of caregivers in the home health care post-acute environment, even though these professionals are key to the outcomes of care(4). The majority of the available literature is devoted to particular disease states or hospital, and there are knowledge gaps regarding the specifics of caregiver issues in the context of home health and the transition of caregivers to home. This gap in research is especially relevant with the population of caregivers, the needs of care recipients, and home settings that can be described as a characteristic of this environment.

The conceptual model of explaining these multifaceted caregiver experiences must have models that recognize the interdependence between care receivers, caregivers and formal service providers in a home context. Conventional care models that emphasize the patient needs or provider interventions do not reflect the dynamic process and mutual roles that define successful home-based care. To understand it more comprehensively, one needs to consider the capabilities of caregivers, environmental concerns and how both formal and informal care systems can be connected to achieve the best results.

This qualitative study aims to enlighten the lived experiences of the caregivers dealing with functional needs of older adults in the post-acute home health care environment and offer insights that can be used in improving practices, policy formulation and future investigations in this vital field of healthcare delivery.

2.Learning Dependent Care Relationships

The theoretical perspective on which the conceptual basis of studying the experiences of caregivers in post-acute home health care is based is based on theoretical perspectives which acknowledge the relational character of the process of caregiving and the multidimensional interplay of personal competence and abilities, environmental variables, and system facilitations. The Theory of Dependent Care, which is given as an expansion of the Self-Care Theory to Orem, is one of the more apt theory frameworks to consider when it comes to explaining how caregivers negotiate the issues of providing older adults with functional limitations in the home environment.

This theoretical approach views the relationships of care as dynamic systems of multiple and interconnected factors: the dependent person with certain limitations of self-care, the caregiver with different capabilities and resources, the complexity of the necessary tasks of care, and the home environment in general with the opportunities and services available. In contrast to the linear models, which view the caregivers as mere gap fillers in the patient capability, the given framework acknowledges the active decision-making process by caregivers, which includes assessment, planning, intervention, and evaluation actions, comparable to the work of professional healthcare providers(5).

Dependence care relationship is typified by continuous negotiation between care needs and preferences of the care recipient, the ability and willingness of the caregiver to give the care and the environmental conditions that enable or limit effective care giving. This process of negotiation is especially complicated during the post-acute period where the care requirements might be fluctuating swiftly, the confidence of the caregivers might be dubious, and the involvement of professional services into the care equation introduces several variables to the picture.

At the heart of this theoretical approach is the understanding that the caregiver has distinctive knowledge, skills, and relationships which are not duplicable by professional providers. Their knowledge of the personality of the care recipient, his/her preferences, routines, and history will be a context that will help differentiate care approaches. Nevertheless, caregivers are also restricted in their understanding of medical illness, technical expertise and physical capabilities that might need to be supplemented with education, training or direct medical service delivery.

The theory intends to highlight the significance of the agency of the caregiver and decision-making power of the caregiver in the relationship of care. This framework also acknowledges the role of caregivers as active collaborators who make complex decisions regarding the priorities of care, the allocation of resources, and intervention plans, given their own perspective and their circumstances instead of being passive recipients of professional teaching. This awareness has significant implications in terms of the way professional providers engage caregivers in education and support, which implies the necessity of collaborative and not commanding methods.

Environmental factors within the dependent care framework encompass not only the physical characteristics of the home setting but also the broader context of available resources, social supports, and service systems. Home environment offers both benefits and setbacks to care delivery, with benefits of familiarity and privacy and possible drawbacks of not having the safety-enhancing features and accessibility modifications required by a person with functional limitations. The perception and adaptation of caregivers to their environments to aid the care activities would give an insight into how they solve problems and the resources they require.

The fact that formal services, including home health care, have been integrated into the dependent care system introduces a further complication that should be taken into account. Professional providers come into the established care relationships with their own assessment tools, intervention methods and outcome expectations that may or may not be consistent with the current practices and preferences of caregivers. Most post-acute services are temporary, which further increases the urgency of the efforts to combine both formal and informal care strategies and equip caregivers with the skills to help them manage care independently(6).

This theoretical framework also recognizes how dependent care relationships change as time goes by. Care requirements, the ability of caregivers and environmental conditions all transform and care strategies must continuously change and evolve. All these changes can be very fast in the post-acute period when patients are getting better after the acute illness or adjusting to new functional restrictions, posing specific challenges to caregivers who constantly have to evaluate and adjust their care approaches.

The Theory of Dependent Care acknowledges that the achievement of successful care outcomes are not only based on the ability to address the immediate physical needs of the care recipients but also the ability to maintain the capacity and well being of the caregiver over time. The caregiver burden, stress, and health issues can infringe the quality and sustainability of care, and caregiver support and preparation are the key elements of an efficient care system. This view highlights the importance of having healthcare providers evaluate and determine the needs of the caregivers in addition to evaluating the needs of the care recipients.

Using this theoretical framework to understand the post-acute home health care setting implies that there are some key considerations to practice and research. First, it brings up the necessity of integrated assessment strategies that do not just study the needs of the patients but also test the capabilities of the caregivers, environmental conditions, and the current dynamics of the relationship between the caregiver and the recipient. Second, it implies that successful interventions need to be designed based on the specifics and conditions of individual caregiver-care recipient pairs and not adopt some generalized method of intervention. Last, it highlights the significance of equipping caregivers to manage care independently by leveraging on their current strengths and working on those that have been identified.

This theoretical background will offer the conceptual framework on the basis of which the caregiver experiences in the given research are analyzed and interpreted, and the complex dynamics affecting care outcomes in the post-acute home health care environment are understood.

3.Methodology

The methodological design to be used to explore the experiences of caregivers in post-acute home health care setting needed to pay close attention to the research design aspects that might help in the attainment of complex and nuanced experiences that caregivers undergo and still allow the scientific rigor of the study. Qualitative descriptive approach was chosen as the most suitable treatment of the main research question of the study that will focus on how the caregivers explain their experiences of handling the functional needs of the older adults undergoing the services of post-acute home health care(7).

The qualitative descriptive studies are defined by their adherence to the proximity to the wording and experience of the participants and the ability to offer a deep, naturalistic descriptions of the phenomena of interest. This approach to methodology was especially suitable to examine the views of caregivers due to its focus on the voices and meanings of participants and the absence of a set of theoretically predetermined constructs or analyses that could be imposed on the participant population. It was aimed to create the rich and detailed accounts of the caregiver experiences that might lead to practice improvement as well as to inform future research directions.

Sampling was based on maximum variation principles which meant that different caregiver outlooks and experiences were represented. The understanding that the populations that care about caregivers are highly diverse in terms of racial and ethnic background, types of relationships, living arrangements, and experiences of caregiving, informed the purposeful actions of recruiting participants who reflect their diversity. About 60 percent of all caregivers in the country belong to racial and ethnic minority groups and thus their representation is necessary to have various results that may be applicable to a wide scope of caregivers.

Recruitment processes were carried out in collaboration with a big nonprofit home health care agency in the northeastern part of the United States that served different populations living in urban, suburban, and rural setting. The initial identification of eligible patients was achieved through use of certain criteria such as recent hospitalization, sixty-five years or older and presence of informal caregivers who would help with activities of daily living or instrumental activities of daily living. The study involved patients with both skilled home health care services and those with longer-term home and community-based services, reflecting the fact that many of the elderly are offered multiple kinds of formal support services.

The caregiver eligibility criteria were English language proficiency and cognitive ability that was measured by standardized screening tools. Such criteria were needed to guarantee that the participants were able to contribute to the interview discussion meaningfully and give informed consent. Relevant institutional review boards approved the study protocol and all the participants signed informed consent before participating.

The data collection processes were based on semi-structured telephone interviews aimed at investigating the experiences of caregivers according to the theoretical domains that were proposed in the Theory of Dependent Care. There was a collaborative process in which interview questions were generated by more than one research team member and tested in pilot studies with community members. The semi-structured format was used to enable the consistent coverage of the essential topic areas and flexibility to address the individual peculiarities of the experiences of the participants.

Telephone interviewing was chosen as data collection technique due to a number of practical and methodological reasons. Most of the caregivers have a lot of time and other demanding tasks that make face-to-face interviews difficult to time and accomplish. Telephone interviews were more flexible and convenient to participants and they might have provided more comfortable conditions to the participants to talk about personal experiences. Studies have indicated that face to face interviews are similar to telephone interviews in terms of quality of data gathered in most forms of qualitative research questions.

Interview questions were viewed within the four theoretical areas of the Theory of Dependent Care, which include: The nature and demand of care recipients, the difficulty of caring activities, the caregiver, such as preparation and confidence, and the home environment, such as the availability of formal services and family support. The questions were such that they would prompt the presentation of detailed descriptions of the experiences instead of mere factual information and in this manner, participants would be encouraged to provide stories, examples and reflections concerning their experiences of care giving.

All the interviews were recorded digitally with the permission of the participants with the aim of maintaining the accurate language and phrases used by the participants. Accuracy of the transcription was checked by a systematic comparison of transcribed text with its original audio recording. This consideration to the quality of transcription was necessary because the research had to maintain the voices of the participants and remain in close relation to their original words.

Methods of data analysis were based on standard methods of conventional content analysis that requires a systematic scrutiny of transcribed interviews to find patterns, themes, and relations within the data. Independently, two members of the research team listened to all transcripts repeatedly, first to develop familiarity with the overall material, and then to code text fragments systematically using their own words in as many cases as feasible. Group discussions between team members helped to cluster similar codes into larger topics and themes.

The credibility of findings was also improved by several approaches advised in qualitative research such as triangulation of the investigator, member checking and the creation of complete audit trails that record analytical judgments. The most frequently used codes were tested on inter-rater reliability and the agreement between coders was high. Findings of the study were also discussed with a community advisory board that comprised former patients and caregivers to assess the relevance and accuracy of interpretations.

The interpretation methodology preserved the qualitative descriptive methodology with its adherence to limited transformations of participant information, such as extensive direct quotations, and the voice of participants to be at the heart of the discussion of results. Themes were arranged by the domains with the theoretical frameworks and kept close to the real experience and words of the participants.

The demographic and contextual data were gathered so as to create a background information on the views of the participants but keeping the focus on the experiential and not quantitative data. These data were caregiver factors (age, gender, race and ethnicity, education, employment status, and relationship to care recipient) and caregiving situation factors (length of caregiving experience, and living arrangements).

The number of participants was determined by principles of data saturation, not by fixed numbers, and the recruitment process was in progress until no new themes or views appeared in the course of the further interviews. At twenty participants, the sample was diverse and sufficiently deep to answer the research questions and was small enough to be subjected to the intensive analytical procedures needed in qualitative research.

This methodological approach gave a sound basis to the study of the caregiver experiences, keeping the flexibility and responsiveness that define a good qualitative research.

4.Results

This study provides evidence of the complexity of the caregiver experience in post-acute home health care facilities, which sheds light on both the difficulties and adaptive mechanisms that define such complicated care relationships. Twenty caregivers were interviewed in-depth, and they represented a wide range of backgrounds and situations of care giving older adults that functions in a diverse way that would give a comprehensive understanding of the lived experience of supporting older adults with functional needs in critical transitional phases.

The individuals participating were very diverse in their individual attributes and care giving situations. The age of their respondents was twenty-nine to eight4 years and mean age of fifty-eight years, indicating that the burden of caregiving cuts across several generations and life phases. Most of the participants were women, which was also aligned with national trends of informal caregiving, but the presence of male caregivers added valuable insights to the ways that gender can potentially affect the process of caregiving and caregiving practices(8).

Participants were racially and ethnically diverse, with thirty five percent reporting white ethnicity, forty percent reporting black ethnicity and twenty five percent responding with Latino or Hispanic ethnicity. This allocation was higher than national averages of minority representation in the research works and offered an essential understanding of how cultural variables can be used to change the attitudes and experiences of caregiving. Educational levels were also quite different, and seventy percent of the participants obtained some college education, which may indicate that caregiving issues are not limited to educational levels or even socioeconomic status.

The employment status of the respondents demonstrated the juggling process that most caregivers have to balance between the work and the caregiving activity. One-half of the respondents continued to work part-time or full-time with forty percent of the sample retiring. The given distribution depicts a fact that caregiving obligations tend to overlap with the most productive years of the career, which generates competing demands that may put personal and career relationships under tension.

Caregiver-care recipient relationships were predominantly family relationships with 65 per cent. caring about their parents and reduced percentages caring about their spouses or siblings and other relatives. Caregivers were equally divided in terms of living arrangements with half living with care recipients and the other half living apart. These varied living conditions posed unique problems and benefits to care management strategies.

Participants had a long background in caregiving and had a range of three to thirty-six years of experience and an average of fourteen years. This observation was a little surprising, considering the attention towards post-acute care transitions, yet it was an indication of the fact that most of the participants had been offering some sort of assistance before the recent hospitalization. The shift to a more intensive caregiving after hospitalization was not the foundation of new responsibilities, but the continuation of the old relationships and care patterns(9).

Another meaningful aspect of the caregiving experience was obtained through self-reported health status among caregivers. They rated their health as excellent and very good as forty five percent and good to fair as fifty five percent. It is worth noting that none of the respondents indicated that their health was poor, which is likely to be a symptom of recruitment biases and the overall inclination of caregivers to downplay their own health issues when they are concerned primarily with the need of the care recipient.

The reports made by caregivers like those on functional needs of care recipients showed complicated processes of continuity and the change issues after hospitalization. Several caregivers stressed that the existing functional limitations were still a challenge but not a novelty and would talk about how it has always been that way to explain the needs of the care receivers. Nevertheless, this continuity was moderated by the understanding that hospitalization tended to worsen already existing issues, or introduce new complications that had to be adaptively addressed.

Caregivers also exhibited advanced knowledge on the issue of several factors that cause functional decline on care recipients. They have singled out certain physiological symptoms such as balance issues, strength deficiencies, and pain as the main functional issues. Also, they identified psychological and emotional issues like the unwillingness to accept assistance or the desire to be independent that made it difficult to deliver care.

The extent of caregiving activities that participants explained was broad based and involved the basic activities of daily living as well as activities that are more intricate, the instrumental activities. Caregivers described their work by saying things such as I basically have to do everything since their work as support involved such wide-ranging duties. These tasks comprised of personal care which included bathing and dressing, mobility, domestic tasks like meal preparation and money management and healthcare coordination tasks.

Of particular interest was the description by caregivers of their advocacy and coordination roles, their metaphorical descriptions of their relationships with providers and systems such as fighters, watchdogs, and chasers. These labeling terms showed the proactive, even confrontational styles, which caregivers were obliged to use in order to guarantee proper care and services to their loved ones. The use of language of fighting to secure services and chasing down of providers implied that healthcare systems could at times present as a roadblock but not an enabler to caregivers.

Adaptive coping styles of managing the functional needs showed problem solving abilities and creativity among the caregivers and relied on the practical and emotional bonds. There was much talk of exact observation and adapting, and such expressions were frequently used to describe the processes of observation and fine-tuning, such as; I study her so that I can see how I could be of more help. The typical measures used to promote safety and independence included environmental adjustments and purchase of equipment and regular modifications.

The origins of caregiver confidence and competence indicated some valuable information regarding how people gain caregiving abilities. The experience proved to be the most dominant source of confidence with a majority of participants explaining how years of caregiving had equipped them to face the present challenges. Also, the sources of knowledge and perseverance in overcoming care challenges were often mentioned by participants in the context of natural instinct and love-based motivation.

5.Conclusion

The overall analysis of the experiences of caregivers in the post-acute home health care facilities provides the significant role of informal caregivers as the principal sources of successful older-adult healthcare transitions. These results help highlight the extraordinary strength and adaptive ability that defines successful caregiving relationships and the high stakes and unmet needs that undermine caregiver well-being and, by extension, the care outcome. The opinions of caregivers sampled in this study are a valuable piece of advice to inform health professionals, policy makers, and researchers working on enhancing support machinery and intervention strategies to handle this underserved but important subset of the population.

The main conclusion that the caregiving in the post-acute care is an amplification of already existing relationships and responsibility and not a completely new role formation has far-reaching consequences on the way healthcare systems can prepare and support caregivers. Instead of viewing caregivers as novices who need fundamental training, providers need to identify and build on prior knowledge and understand the areas that may need further knowledge, skills or resources to increase the effectiveness of care as well as boosting the confidence of caregivers. This awareness implies the necessity of personalized evaluation strategies that determine both the areas of strengths and weaknesses in the preparation of the caregivers instead of adhering to standardized teaching strategies.

The multifacetedness of the caregiving duties that are evident in the description of the participants highlights the inefficiency of interventions that are tightly specific and only focused on medical or clinical components of care. Caregivers also act as care coordinators, care advocates, environmental engineers and relationship managers on top of offering direct physical support. The best support strategies should consider and support all these areas of responsibility with multifaceted resources and training opportunities that encourage caregivers to meet the multivaried nature of duties.

The confrontational dynamics that most caregivers reported with healthcare systems symbolize missed chances of collaboration and partnership that have the potential to affirm the overall caregiver performance and care recipient outcomes. Health care organizations should review their policies, procedures and staff training strategies in order to determine and remove those factors that are bringing barriers between providers and the care givers. To construct genuinely collaborative methods, the underlying changes in organizational culture are necessary to place caregivers as a central partner and not an incidental actor in the process of care delivery.

The loneliness of a significant number of caregivers emphasizes the extreme significance of the creation of intervention strategies that meet the requirements of social and emotional support and practical skill training. The healthcare providers need to establish the skills to evaluate the family support systems, define at-risk caregivers who may be isolated and overburdened, and refer these caregivers to the relevant resources and services. This could involve the broadening of conventional healthcare functions or the establishment of relationships with community institutions that are capable of offering continuous assistance and networking possibilities.

The time aspects of needs among caregivers exposed in this study indicate that successful support should be continuous and flexible as opposed to being loaded at the transition stage. The needs of caregivers change as the conditions of the care recipients change, caregivers gain experience and confidence and formal services are modified or discontinued. These changing needs should be incorporated in the support systems by creating flexible models of service delivery and continuous evaluation and adaptation methods.

The variation of the background of caregivers and situations presented in this research supports the necessity of culturally responsiveness and individual approach to intervention. The healthcare professionals need to acquire cultural competence and assessment abilities that would help them identify and address the needs of diverse caregivers, their preferences, and resources adequately. This necessitates the abandonment of one-size-fits-all models in favor of more complex knowledge of how cultural, socioeconomic and individual influences play out in caregiving experiences and support needs.

The results of the study that existing services provided by the home health care have a tendency to render caregivers unprepared to take care of patients alone imply significant implications to policy in the form of reimbursement models and service approval practices. Principles of policy that policymakers ought to observe are the increased coverage of caregiver-targeted interventions, longer spans of care according to an individual as opposed to a standardistic criterion and the emergence of new categories of services that directly meet caregiver preparation and support needs.

Healthcare institutions that aim at enhancing post-acute care results have to appreciate that the well-being of caregivers has a direct correlation on the results and quality of care recipients. This identification indicates that systematic methods to caregiver assessment, support, and outcome follow-up are the required elements of the post-acute care delivery. Improvement initiatives must include caregiver satisfaction/preparedness variables as well as classical patient-oriented measures.

The fact that most caregivers gain most of their knowledge and confidence through experience and not through formal training is an indicator of significant implications in designing educational interventions. Practical learning should be an important part of successful caregiver education, with continuous feedback and support provided, and the development of skills and confidence gradual, instead of assuming that the skills can be mastered quickly after instructional sessions.

Future research needs arising during this inquiry are longitudinal investigations that investigate changes in caregiver experience and need during care transitions, comparative studies that identify differences between caregiver groups and care settings, intervention studies that test a particular caregiver preparation and support strategy and economic analyses that assess the cost and benefit of improved caregiver support programs.

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Conflicts of interest

The authors have no conflicts of interest to declare

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