

Health Professionals Attitudes on Engaging Multimorbidity Patient Families and Caregivers as Partners in Chronic Health Care

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Abstract

Multimorbidity, the occurrence of two or more chronic health disorders, is thought to affect about one-fourth of the Australian population with older age groups having a higher prevalence. People with multimorbidity (PwM) frequently have extremely complex healthcare needs, are more prone to experience depression and depend more frequently on unpaid family caregivers to help them manage their diseases. PwM and their family caregivers (hereinafter referred to as caregivers) report facing particular difficulties, such as juggling a variety of (and frequently disjointed) healthcare services and practitioners, difficulty communicating with health professionals (HPs) to obtain crucial medical information, managing multiple medications, and uncertainty about potential interactions between symptoms and treatments. While there has been an increased emphasis on better.

Keywords: Patient families • Chronic health care • Health professionals attitudes

Introduction

Because of their caring responsibilities, caregivers frequently face a heavy burden and poor physical and mental health results. The load on caregivers of PwM who frequently handle numerous difficult healthcare activities is notably increased. As a result of the heavy load of their caring position, it is not surprising that caregivers with PwM typically experience stress, anxiety, and depression and report severe negative impacts on their social, professional, and family life. According to a recent review of the needs of PwM caregivers, there are significant barriers for caregivers to interact with healthcare professionals (HPs) and the larger healthcare system. These barriers include reports of poor communication with and between HPs, poor continuity of care, and poor care coordination, which force caregivers to: Similar difficulties arise when HPs provide PwM with medical care. HPs frequently struggled to manage the complicated healthcare demands of this group, juggling competing goals without the proper clinical guidelines, and working within a disjointed healthcare system, according to a comprehensive assessment of primary care clinicians' experiences treating PwM [1].

Further reports from PwM and their caregivers indicate that many specialists and other healthcare professionals lack communication skills are unaware of their patients' medical histories, and work in isolation. Indeed, the issues experienced by caregivers of PwM, when there are several, frequently interrelated illnesses, are made more difficult by the walled architecture of healthcare, which is typically intended to address acute episodes and specific disease concerns. Additionally, the prevalent care paradigm in the multimorbidity situation is a patient-centered approach. HPs frequently described their approach to managing multimorbidity as being influenced and

guided by the priorities of the patient and caregivers. Contradictory viewpoints were recorded by some patients and caregivers, who said that they frequently felt dictated to by medical experts. It is obvious that more research is required to fully comprehend the various strategies used by HPs to manage PwM and their caregivers. Despite numerous studies demonstrating that HPs are aware of the need for better supports for PwM carers, the study did not examine HPs' strategies for meeting their specific requirements. Additional study is required to pinpoint the precise supports utilised [2].

Description

The main causes of disability and death in New York State and the entire country are chronic diseases like heart disease, cancer, diabetes, stroke, and arthritis. Over 40% of New York individuals have a chronic illness, and 23% of all hospitalizations in the state are brought on by these conditions. In the state of New York, chronic diseases account for six out of every ten fatalities. In New York State, heart disease and cancer are responsible for more than half of all fatalities. Despite being widespread and expensive, many chronic diseases can be avoided. You have the power to alter your lifestyle, which is linked to many chronic conditions. Avoiding cigarettes, increasing physical activity, and eating nutrient-dense foods can all assist prevent? [3].

Each participant provided a written informed permission to participate in the study and to permit us access to their medical records after receiving an informational letter regarding it and the interview process. From the medical records, we were able to gather data on diagnoses and the quantity of hospitalizations. The Danish Data Protection Agency granted permission for the study to be carried out. According to the wishes of the participants, semi-structured interviews were performed at the participants' residence (home or nursing home), in a conference room at the hospital, or over the phone (for one interview). Each interview lasted between 45 and 60 minutes, and they were all audio recorded and fully transcribed [4].

With primary inspiration from Graneheim and Lundman, the transcripts of interviews were coded and organised inductively utilising manifest qualitative content analysis. First, to get a feel of the overall content, two writers (M.L.S. and D.H.) examined the transcripts of the interviews. Second, the text was divided into units of meaning that were then compressed and aggregated to generate groups and subcategories using an inductive approach to data and the Nvivo 10 programme. Categories and sub-categories were first created independently by two authors (M.L.S. and D.H.), in order to add rigour and

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guarantee reliability and credibility. The categories and sub-categories were then compared and discussed by all authors and an outside researcher with experience in chronic care management [5].

The participants, who were made up of four men and ten women, had an average age of 71.3 years (range 49–88 years). Nine of the participants were single, one was a resident of a nursing home, and four had a partner. Four participants had a recorded diagnosis of mental illness, and participants had an average of 3.4 diagnoses (ranging from 2 to 5). In the year prior to the research, participants experienced an average of 2.4 hospitalizations (range 0-6). Many hospital stays exceeded a week, and some even went over four weeks. Participants also displayed lower functional capacity; the majority of them need electric wheelchairs or Zimmer frames to walk. The majority of individuals also mentioned having little social networks and feeling lonely. From the analysis of the interviews, four categories indicating various chances to enhance care were identified. There were two subcategories under "Overall experience of care" that dealt with describing the quality of the care received and discussing unsatisfactory encounters. "Focus of care" included sub-categories pertaining to whether the participants felt they were treated as whole persons with multiple conditions and individual needs; how the participants' brief interactions with healthcare professionals affected experiences and outcomes; and how the specialisation of care and lack of cross-specialty treatment affected the therapeutic process. "Medication management" comprised subcategories for sharing medication-related data across physicians and reconciling prescriptions. Subcategories of "care coordination" included those pertaining to the several providers participating in care pathways, how follow-up was handled, and how care was provided.

Conclusion

The research generally showed that participants' descriptions of their care experiences were divided into two categories. The same participants frequently stated their general satisfaction and gratitude for their treatment at the conclusion of the interviews, in addition to identifying various parts of the care process that did not work or might be improved. Participants' comments regarding their overall happiness with care appeared to be an attempt to counteract or moderate earlier criticism of their experiences. According to one participant, "In general I have to say, except for the final time when I must have been under a poor star, they [the healthcare personnel] have been quite skilled and kind and most of the time there was a good outcome. Participants

expressed their belief that they were not treated as entire people with a complex state of health that includes a number of illnesses and that they were not seen as such. They blamed the lack of time and resources in the healthcare system overall as well as the specialisation of hospital care for this. Many participants reported that they did not feel accepted as whole individuals with numerous clinical and emotional difficulties. Some patients stated that they believed medical professionals could only handle one issue at a time or had limited time. The fact that none of the several healthcare experts involved in their care appeared to have a thorough comprehension of their therapy or the ability to determine if on-going treatment was suitable or needed adjustment caused participants to report feeling anxious.

Acknowledgement

None.

Conflict of Interest

None.

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