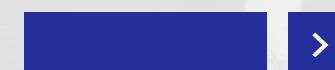




SEKOLAH TINGGI ILMU KESEHATAN
NOTOKUSUMO
YOGYAKARTA

PERSPEKTIF KEPERAWATAN: *CHRONIC DISEASE*



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STIKES NOTOKUSUMO

OUTLINE:

1. Pendahuluan
2. Model Keperawatan dalam Manajemen Penyakit Kronis
3. Peran Perawat dalam Manajemen Penyakit Kronis
4. Penyakit Kronis Umum dan Intervensi Keperawatan
5. Tantangan dalam Keperawatan Penyakit Kronis
6. Arah Masa Depan Keperawatan dalam Penyakit Kronis
7. Kesimpulan



PENDAHULUAN



a. Definisi Penyakit Kronis

Penyakit kronis adalah kondisi kesehatan yang berlangsung lama (lebih dari enam bulan) dan memerlukan perawatan berkelanjutan.

Penyakit ini sering berkembang secara perlahan dan dapat berdampak signifikan pada kualitas hidup pasien.

Contoh penyakit kronis meliputi:

- Diabetes Mellitus
- Hipertensi
- Penyakit Jantung
- Penyakit Paru Obstruktif Kronis (PPOK)
- Kanker
- Stroke

PENDAHULUAN



b. Peran Perawat dalam Manajemen Penyakit Kronis

Perawat memiliki peran penting dalam merawat pasien dengan penyakit kronis, antara lain:

- Memberikan edukasi kesehatan
- Membantu manajemen gejala
- Memberikan dukungan psikologis dan emosional
- Mengkoordinasikan perawatan pasien
- Menjadi advokat bagi kebutuhan pasien

Model Keperawatan dalam Manajemen Penyakit Kronis



a. Model Perawatan Penyakit Kronis (Chronic Care Model – CCM)

Model ini digunakan untuk meningkatkan kualitas perawatan pasien dengan penyakit kronis. Komponen utama CCM meliputi:

- ☐ **Dukungan Manajemen Diri** – Membantu pasien mengambil peran aktif dalam mengelola penyakit mereka.
- ☐ **Desain Sistem Pelayanan** – Mengoptimalkan peran tenaga kesehatan dalam tim perawatan.
- ☐ **Dukungan Pengambilan Keputusan** – Menggunakan panduan berbasis bukti untuk meningkatkan perawatan pasien.
- ☐ **Sistem Informasi Klinis** – Pemanfaatan rekam medis elektronik untuk pemantauan pasien.
- ☐ **Sumber Daya Komunitas** – Menghubungkan pasien dengan layanan dukungan di masyarakat.

The Chronic Care Model



Model Keperawatan dalam Manajemen Penyakit Kronis



b. Pendekatan Holistik dan Berpusat pada Pasien

- ☐ **Aspek Biologis** – Pengelolaan gejala, kepatuhan obat, dan perubahan gaya hidup.
- ☐ **Aspek Psikologis** – Menangani stres, kecemasan, dan depresi akibat penyakit kronis.
- ☐ **Aspek Sosial** – Melibatkan keluarga dan sumber daya komunitas dalam perawatan.
- ☐ **Aspek Spiritual** – Memberikan perawatan yang sensitif terhadap budaya dan kepercayaan pasien.

Peran Perawat dalam Manajemen Penyakit Kronis



a. Promosi Kesehatan dan Pencegahan

Perawat berperan dalam edukasi dan pencegahan penyakit dengan:

- ☐ Mendorong pasien untuk berhenti merokok
- ☐ Mempromosikan pola makan sehat dan aktivitas fisik teratur
- ☐ Mengajarkan teknik manajemen stres

b. Deteksi Dini dan Pemantauan

- ☐ Melakukan skrining dan identifikasi faktor risiko
- ☐ Memantau perkembangan penyakit dan mendeteksi komplikasi lebih awal

c. Manajemen Gejala dan Pengobatan

- ☐ Mengajarkan pasien cara mengelola gejala penyakit mereka
- ☐ Memastikan kepatuhan pasien terhadap terapi obat
- ☐ Menangani efek samping obat

Peran Perawat dalam Manajemen Penyakit Kronis



d. Edukasi Pasien dan Pemberdayaan

- ☐ Melatih pasien dalam strategi manajemen mandiri, seperti pemantauan gula darah pada diabetes atau tekanan darah pada hipertensi
- ☐ Meningkatkan keterlibatan pasien dalam pengambilan keputusan terkait perawatan mereka

e. Perawatan Paliatif dan Akhir Hayat

- ☐ Memberikan perawatan untuk mengurangi rasa sakit dan meningkatkan kenyamanan pasien
- ☐ Mendukung pasien dan keluarga dalam proses pengambilan keputusan terkait perawatan akhir hayat

Penyakit Kronis Umum dan Intervensi Keperawatan



a. Diabetes Mellitus

- ☐ Pemantauan kadar gula darah dan terapi insulin
- ☐ Edukasi tentang pola makan sehat dan olahraga
- ☐ Pencegahan komplikasi seperti neuropati dan retinopati

b. Hipertensi (Tekanan Darah Tinggi)

- ☐ Edukasi tentang diet rendah garam dan olahraga rutin
- ☐ Pemantauan kepatuhan terhadap pengobatan
- ☐ Teknik manajemen stres

c. Penyakit Paru Obstruktif Kronis (PPOK)

- ☐ Pelatihan teknik pernapasan dan terapi oksigen
- ☐ Mendorong pasien untuk berhenti merokok
- ☐ Manajemen infeksi pernapasan

Penyakit Kronis Umum dan Intervensi Keperawatan



d. Penyakit Jantung

- ☐ Pemantauan tanda vital dan gejala gagal jantung
- ☐ Mendorong rehabilitasi jantung
- ☐ Edukasi tentang perubahan gaya hidup dan aktivitas fisik

e. Kanker

- ☐ Manajemen efek samping kemoterapi dan radioterapi
- ☐ Dukungan emosional dan psikososial
- ☐ Perawatan nyeri dan paliatif

Tantangan dalam Keperawatan Penyakit Kronis



- ☐ **Ketidakpatuhan Pasien** – Beberapa pasien mengalami kesulitan dalam menjalani terapi secara konsisten.
- ☐ **Beban Emosional dan Psikologis** – Penyakit kronis dapat berdampak pada kesehatan mental pasien.
- ☐ **Hambatan dalam Sistem Kesehatan** – Keterbatasan sumber daya dan koordinasi layanan kesehatan.
- ☐ **Kelelahan Caregiver** – Stres pada keluarga dan pengasuh pasien.
- ☐ **Kendala Finansial** – Biaya tinggi untuk perawatan jangka panjang.

Compliance and Chronic Disease

PEARL S. GERMAN

SUMMARY The shifting demographics of the population and increasing skill in treatment of chronic disease in this country have combined to make compliance a topic of greater salience than ever before. General issues of compliance are a necessary background to specific issues of compliance with regimens for single diseases such as hypertension. The definition of compliance continues to be modified, and examination of past work reveals certain consistencies in studies of compliance. Non-compliance is higher in chronic conditions, in activities requiring change in life-style, and in clinician-initiated visits. Noncomprehension of instructions is held to be the most frequent cause of noncompliance. Noncompliance is a threat to the course of treatment, increases unnecessary diagnostic procedures, and confounds evaluation of effectiveness. Factors related to compliance have been identified with regard to certain patient and disease characteristics, amount of support in the immediate environment, and the nature of the doctor-patient relationship. Older patients are often at greater risk in understanding regimens because clinicians educate this group less often, because symptoms are misunderstood by both patient and provider, and because of greater complexity in both conditions that are being treated and number of drugs and other aspects of treatment required. Methods of improving the doctor-patient relationship have been urged most recently as a means through which compliance can be increased. (Hypertension 11 [Suppl II]: II-56–II-60, 1988)

KEY WORDS • compliance • elderly • chronic disease • doctor-patient relationships

THE formidable success of the health care system in the control of infectious disease makes it certain that ongoing emphasis will be on the improvement, maintenance, rehabilitation, and palliation of chronic conditions. Further, this particular focus in health care will be relevant for an increasing number and proportion of the population and over longer periods of time. The changing epidemiological picture ensures that we will continue to keep a greater number of chronically ill people alive for longer periods.¹⁻³ This has implications not only for clinical practice but for research, teaching, and policy and planning. In clinical practice and in research, particularly, the accelerating concentration on chronic disease and its treatment makes the consideration of compliance unavoidable as a crucial issue in care and its evaluation.

This report, in reviewing general issues in compliance, serves as the background necessary for more specific applications of compliance, that is, compliance in hypertension therapy. With this as an objective, an overview is presented of the past work on

compliance in general, including discussion of the different aspects or discrete elements of the concept. In the process, some support will be offered for the assertion that compliance is an essential part of chronic disease treatment.

Definition of Compliance

There has been dissension over the word *compliance*, and it is disliked by many clinicians, researchers, and patients because of the authoritarian ambience it radiates. Sackett and Haynes⁴ in their landmark work on compliance comment on this but in the end reject the broader “therapeutic alliance” because they feel it is cumbersome. Despite the recognized controversy, they suggest that a working definition of compliance should be and is in their work “the extent to which the patient’s behavior (in terms of taking medications, following diets or executing other life-style changes) coincides with the clinical prescription.” They added “no matter how it was generated.”⁴ But there is an additional dimension to compliance considered essential by many, and that includes some concept of joint responsibility, and this dimension has been in evidence increasingly over the years that followed the McMaster’s Conference,⁵ which gave birth to the Sackett and Haynes work on compliance cited previously. Whether this change, adding mutuality to responsibility, has been fueled by the increasingly litigious nature of medical practice is certainly a question that might be raised. However, this is not the only impetus to this

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Culture and Medicine

Emotional dimensions of chronic disease

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Advances in research and the delivery of health care have reduced mortality from disease and extended life expectancy in developed countries. We are living longer, but are we necessarily living better? Those who would have died from their condition may now survive but there is the emotional cost of long-term treatment and medical surveillance to consider (for example, the patient who has had a liver transplant must then continue immunosuppression treatment). Such patients must cope with a chronic condition and yet the emotional dimensions of these conditions are frequently overlooked when medical care is considered. Concepts such as the "sick role" and "illness behavior" have helped us understand the impact of disease and are familiar to most clinicians. Yet challenges still exist in the recognition and management of the psychological and social dimensions of chronic illness.

CHRONIC MEDICAL ILLNESS

Mental illness developing from chronic disease

Patients with chronic conditions often have to adjust their aspirations, lifestyle, and employment. Many grieve about their predicament before adjusting to it. But others have protracted distress and may develop psychiatric disorders, most commonly depression or anxiety. A prospective study of general medical admissions found that 13% of men and 17% of women had an affective disorder.¹ The proportion of patients with conditions such as diabetes or rheumatoid arthritis who have an affective disorder is between 20% and 25%.² Among patients admitted to the hospital for acute care and among patients with cancer, rates can exceed 30%³ compared with a prevalence of depression in the community of about 4%-8%.⁴

It can be difficult to diagnose depression in the medically ill. Physical symptoms such as disturbed sleep, impaired appetite, and lack of energy may already exist as a result of the disease. Sometimes treatment for a medical condition (for example, the use of steroids) may affect the patient's mood, as may the disease process itself (for example hypoxia and infection in a patient with chronic

Summary points

- The emotional dimensions of chronic conditions are often overlooked when medical care is considered
- It can be difficult to diagnose depression in the medically ill but diagnosis and treatment are essential
- Doctors may be well equipped for the biomedical aspects of care but not for the challenges of understanding the psychological, social, and cultural dimensions of illness and health
- Clinicians can play an important part in helping their patients to maintain healthy coping skills
- Clinicians should reflect on the emotional dimensions of their work, including how professional development and training may enhance professional satisfaction and patient care, and the important role that relationships and outside activities have in providing balance

in particular, there are clear links between physical illness, disability, and depression⁷ and increased use of hospital and medical outpatient services.⁸

Despite these difficulties, it is essential to diagnose and treat depression in patients with chronic conditions. Even mild depression may reduce a person's motivation to gain access to medical care and to follow treatment plans. Depression and hopelessness also undermine the patient's ability to cope with pain and may exert a corrosive effect on family relationships.⁶ Although the patient with an incurable medical illness who commits suicide may seem to some people to have acted rationally, most of the patients who commit suicide are also suffering from a depressive illness.⁹ Furthermore, the development of depression in people with a medical illness has been linked to adverse physical outcomes and substantial increases in disability.¹⁰ Patients who become depressed after a cerebrovascular accident have been found to have an increased risk of dying¹¹ and to make significantly less recovery on measures of activities of daily living.¹² The clinical course of heart disease is also influenced by depression, and 9 out

RESEARCH

Open Access

Barriers to accessing health care for people with chronic conditions: a qualitative interview study



Tanja Schwarz¹, Andrea E. Schmidt^{2*}, Julia Bobek³ and Joy Ladurner⁴

Abstract

Background: There is a growing interest in redesigning healthcare systems to increase access to and coordination across care settings for people with chronic conditions. We aim to gain a better understanding of the barriers faced by (1) children with chronic bronchial asthma, (2) adults with non-specific chronic back pain, and (3) older people with pre-existing mental illness/es in Austria's fragmented social health insurance system.

Methods: Using a qualitative design, we conducted semi-structured interviews face-to-face and by telephone with health service providers, researchers, experts by experience (persons with lived/ personal experience, i.e., service users, patient advocates or family members/carers), and employees in public health administration between July and October 2019. The analysis and interpretation of data were guided by Levesque's model of access, a conceptual framework used to evaluate access broadly according to different dimensions of accessibility to care: approachability, acceptability, availability and accommodation, affordability, and appropriateness.

Results: The findings from the 25 expert interviews were organised within Levesque's conceptual framework. They highlight a lack of coordination and defined patient pathways, particularly at the onset of the condition, when seeking a diagnosis, and throughout the care process. On the supply side, patterns of poor patient-provider communication, lack of a holistic therapeutic approach, an urban-rural divide, strict separation between social care and the healthcare system and limited consultation time were among the barriers identified. On the demand side, patients' ability to perceive a need and to subsequently seek and reach healthcare services was an important barrier, closely linked to a patient's socio-economic status, health literacy and ability to pay.

Conclusions: While studies on unmet needs suggest a very low level of barriers to accessing health care in the Austrian context, our study highlights potential 'invisible' barriers. Barriers to healthcare access are of concern for patients with chronic conditions, underlining existing findings about the need to improve health services according to patients' specific needs. Research on how to structure timely and integrated care independent of social and economic resources, continuity of care, and significant improvements in patient-centred communication and coordination of care would be paramount.

Keywords: Healthcare access, Barriers, Chronic conditions, Multimorbidity, Integrated care, Asthma in children, Chronic back pain, Mental illness, Older people, Austria

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Background
Barriers to accessing health and social care represent a key factor in causing health disparities. Regardless of their age, people with chronic conditions often face



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THE COST OF CHRONIC ILLNESS

70% of deaths in the U.S. are caused by chronic illnesses such as diabetes, Alzheimer's disease, cancer, and heart disease.



Did You Know...

90%

Chronic illness accounts for nearly **\$3 trillion** (90%) of the total \$3.3 trillion spent annually in the U.S. on medical care.

60% of adult Americans have some type of chronic condition

40% of adult Americans have two or more chronic conditions

PLANNING AHEAD

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Article

Burden of Caregivers of Patients with Chronic Diseases in Primary Health Care: A Cross-Sectional Study in Greece

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Abstract: Background: In the world of elderly people and people with chronic diseases, caregivers give a solution to caring at home. This study aimed to evaluate the burden of caregivers of patients with chronic diseases in primary health care and identify possible demographic and other determinants of it. Methods: This was a cross-sectional study with a convenience sample, which was conducted in two health centers. The sample comprised 291 caregivers who visited the aforementioned health centers in Patra, Greece. A composite questionnaire was utilized: the first part included demographic data and care-related information and the second included the Zarit Burden Interview and the Depression, Anxiety, and Stress Scale-21 (DASS-21). Results: The highest mean score in the DASS was recorded in the depression subscale and the lowest in the stress subscale. Concerning the Zarit Burden Interview, the highest mean score was recorded in the personal strain subscale and the lowest in the management of care subscale. The highest correlation was recorded between role strain and anxiety and the lowest was between management of care and stress. Similarly, the total score in the Zarit Burden Interview correlated significantly (in a positive direction) with depression, anxiety, and stress. Conclusions: Most of the caregivers of patients with chronic diseases in primary health care experienced a moderate to severe burden (especially in the dimension of personal strain) and moderate depression. The experienced burden was positively associated with depression, anxiety, and stress. There were significant differences in the caregivers' burden according to several demographic and care-related characteristics.

Keywords: caregivers; burden; anxiety; stress; primary health care; chronic diseases

1. Introduction

The increase in life expectancy and advancements in science have led to a situation where the global population is confronted with escalating chronic health issues. According to the World Health Organization (WHO), by 2050, 80% of older individuals will reside in low- and middle-income countries. Moreover, between 2015 and 2050, the proportion of the world's population over 60 years old is projected to nearly double from 12% to 22% [1]. In Europe, over one-third (35.2%) of the population reported at least one chronic health problem in 2021 [2]. Additionally, individuals over 65 often experience limitations in daily activities, necessitating increased support from caregivers and resulting in financial burdens on either the health care system or the patients themselves [3].

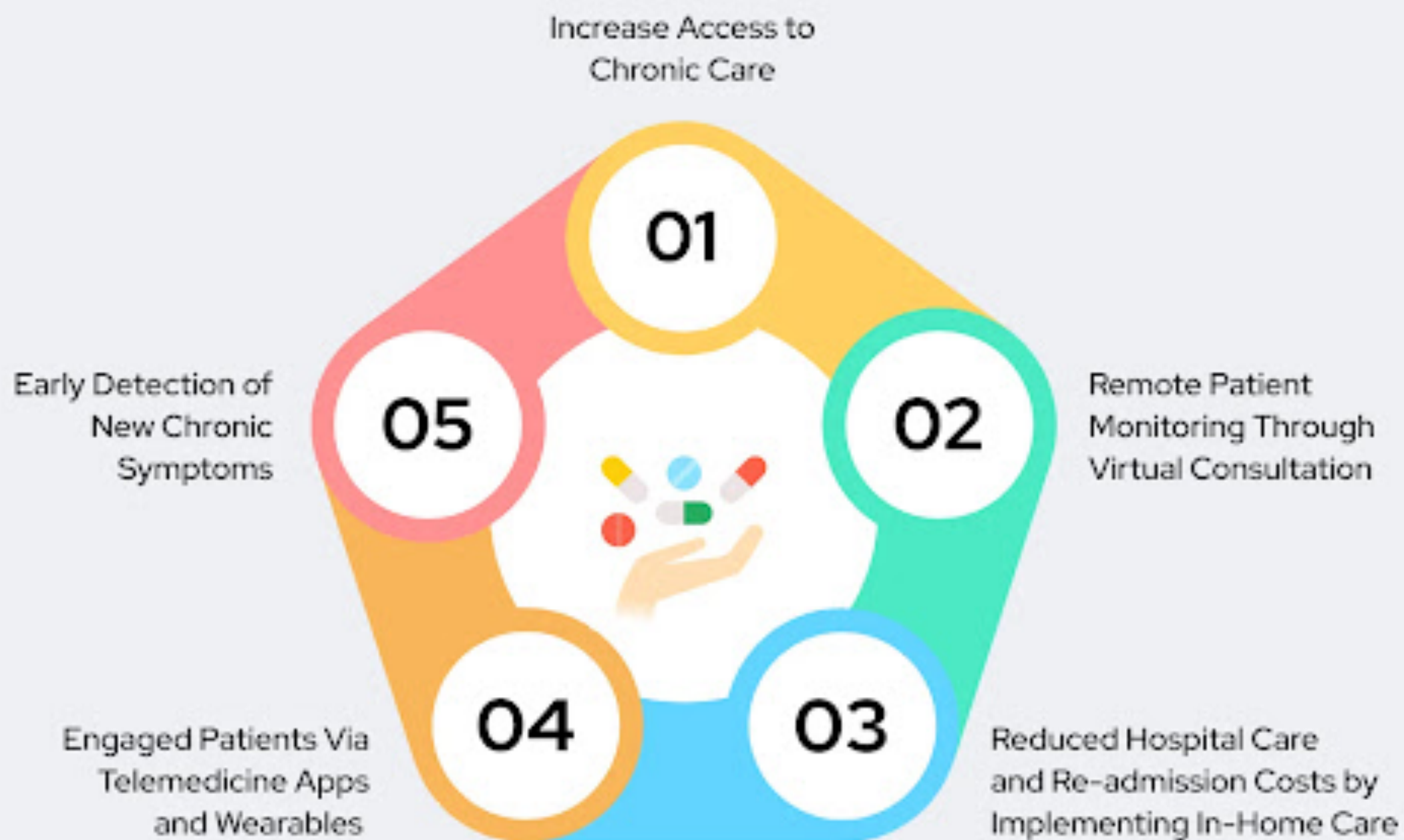
Chronic diseases are defined broadly as conditions that persist for 1 year or more and necessitate ongoing medical attention, restrict activities of daily living, or both. The Centers

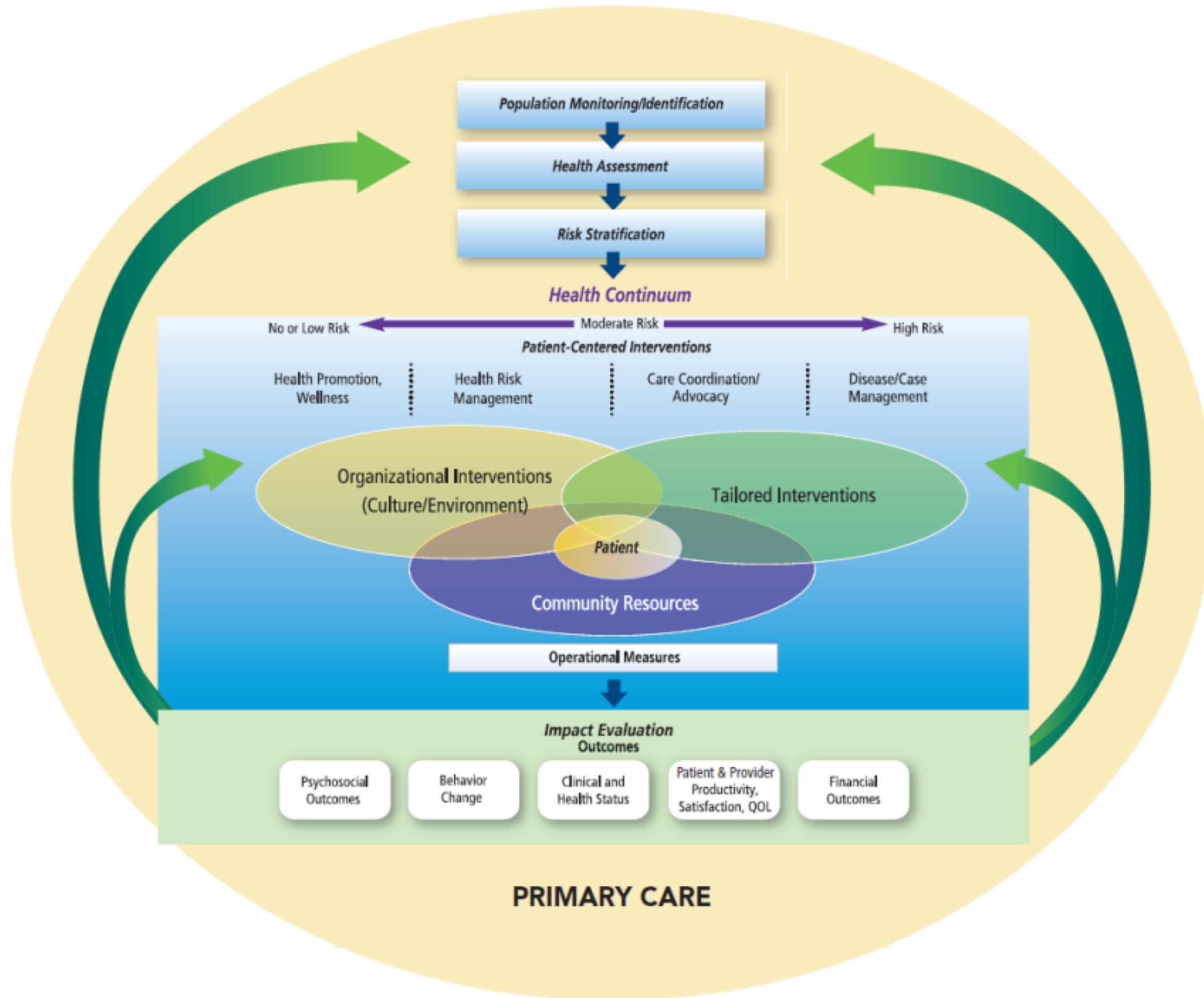
Arah Masa Depan Keperawatan dalam Penyakit Kronis

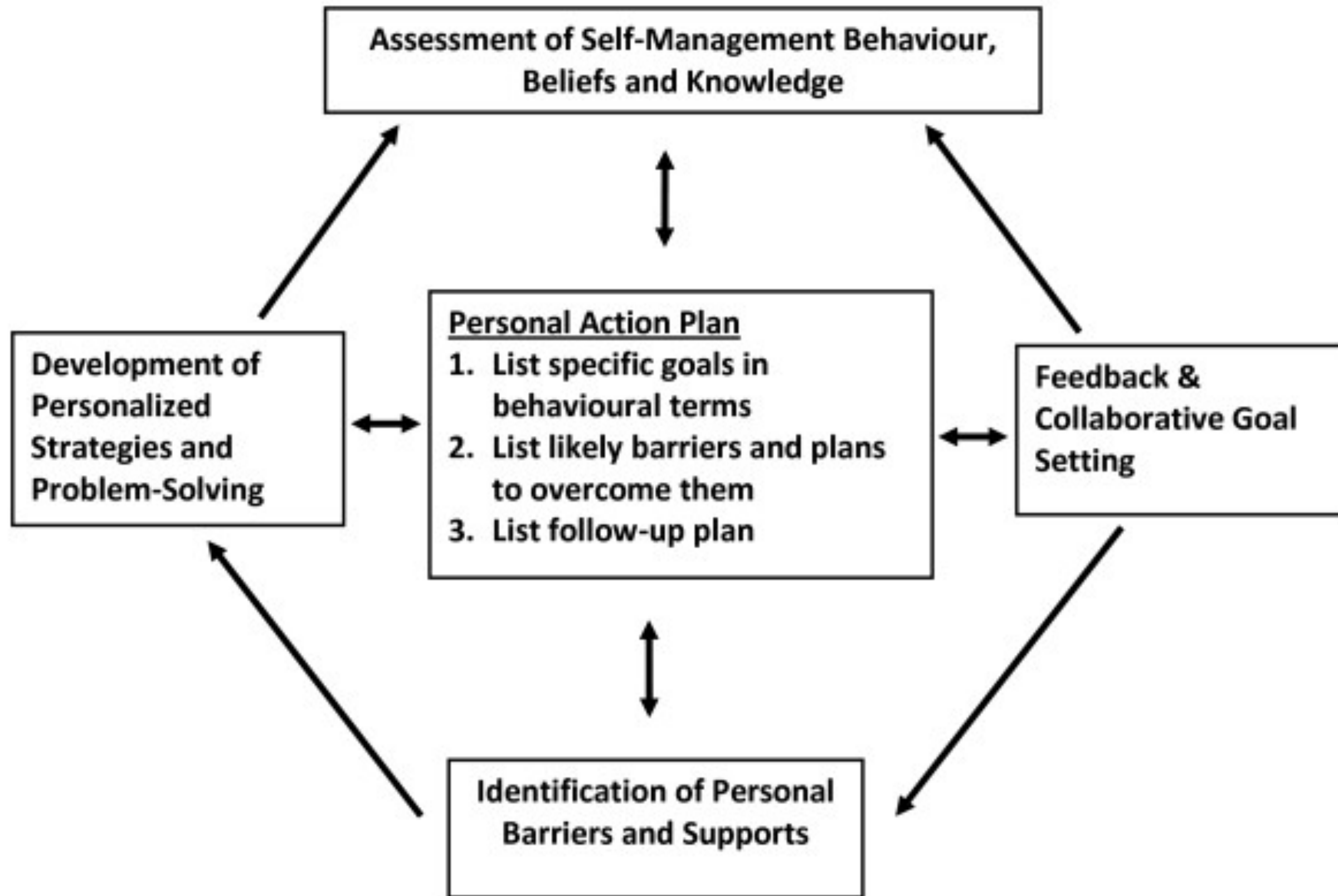


- ☐ **Telemedicine dan Pemantauan Jarak Jauh** – Pemanfaatan teknologi digital dalam perawatan pasien.
- ☐ **Model Perawatan Terintegrasi** – Kolaborasi multidisiplin untuk meningkatkan efektivitas perawatan.
- ☐ **Pengobatan yang Dipersonalisasi** – Perawatan yang disesuaikan dengan karakteristik unik pasien.
- ☐ **Program Berbasis Komunitas** – Perluasan layanan manajemen penyakit kronis ke tingkat masyarakat.

5 Ways Telemedicine Transforms Chronic Disease Management







Strategies for Effective Community-Based Care

- 1 Integrated Care Teams
- 2 Health Education
- 3 Technology Utilization
- 4 Community Engagement
- 5 Policy Advocacy

Kesimpulan

- ❑ Perawat memiliki peran penting dalam perawatan pasien dengan penyakit kronis, baik dalam aspek pencegahan, pengelolaan, maupun dukungan psikososial.
- ❑ Pendekatan holistik dan berbasis pasien sangat penting untuk meningkatkan kualitas hidup pasien dengan penyakit kronis.





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MATUR NUWUN