

Optimizing the Management Mode of Chronic Diseases at Home for the Elderly - Practice and Reflection of Medical Cooperation

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Abstract:

Objective: This study aims to explore how to optimize the management mode of chronic diseases at home for the elderly, and to reflect on the mode of medical cooperation to make suggestions. **Methods:** This study adopted the literature research method to analyze the social impact of chronic diseases in the elderly and the importance of chronic diseases management at home, and proposed that the practice of deeply optimizing the management mode of chronic diseases in the elderly at home should establish a good medical cooperation mode, formulate personalized management plan and regularly implement family medicine visits. **Results:** The optimal management model definitely has a significant impact on the improvement of the treatment effect of chronic diseases, and can also improve the quality of life, thereby reducing the consumption of medical resources. **Conclusion:** By improving the efficiency of medical communication, improving patient education and improving chronic disease management research, this paper provides a more comprehensive and humanized chronic disease management scheme for the elderly.

Keywords:

Management of Senile Chronic Diseases, Health Care Cooperation, Family Medicine Visits, Patient Education, Efficiency of Medical Communication

1. Introduction

The aging population is increasing in our society. Because they suffer from chronic diseases for a long time, the change of physical and mental state and the nature of life attracts people's attention [1]. How to make the existing medical system better adapt to this change, meet the overall needs of the public and the special requirements of elderly people with many diseases, this is the focus of serious exploration. It is committed to optimizing the management mode of chronic diseases in the elderly, hoping to reduce the investment of established medical resources, improve the disease control effect, and strive to improve the quality of life of patients [2].

2. The Social Impact of Chronic Disease in the Elderly and the Importance of Chronic Disease Management At Home

Chronic diseases of the elderly are one of the major challenges facing today's society. With the intensification of population aging, the incidence and mortality of chronic diseases are rising [3]. Chronic diseases of the elderly mainly include hypertension, diabetes, cardiovascular diseases, chronic obstructive pulmonary disease, etc., which bring heavy burden to patients and their families. Patients often require long-term medication, regular visits, diet control and other multi-faceted care, which has a serious impact on the financial, psychological and quality of life of patients.

Patients with chronic diseases such as hypertension and diabetes often need long-term medication to control the condition, if not timely and effective management, easy to occur complications, aggravate the disease [4]. Diseases such as cardiovascular disease and chronic obstructive pulmonary disease are a direct threat to patients' life safety. In society, chronic diseases of the elderly require a lot of medical resources and human and material input, which brings severe challenges to the social medical system and greatly increases the medical cost.

Chronic disease management at home is particularly important [5]. Home is the most common place for elderly patients to live. Through the establishment of an effective management mechanism between family doctors and patients, more convenient health management services can be provided to patients, and the improvement of patients' rehabilitation and quality of life can be promoted. The advantage of chronic disease management at home is that it can better realize personalized treatment and care, effectively monitor the health status of patients, find problems in time and take measures to avoid disease deterioration.

For chronic disease management at home, the importance of medical cooperation is highlighted. The formulation of the treatment plan and the monitoring of the progress of the disease are handled by the doctor, and the task of implementing the doctor's orders, viewing physiological data and daily living care is entrusted to the nurse [5]. The close cooperation of medical staff connects the gap between medical care and forms a professional medical care team to provide patients with a full range of health management services. Such a practice can greatly improve the compliance of patients to treatment, improve the proportion of treatment recovery, reduce the probability of medical accidents, and make the quality of medical care has a new improvement [6].

3. Deeply Optimize the Practice of Chronic Disease Management Mode for Elderly People at Home

3.1. Practice of medical cooperation mode

In the specific operation of the medical cooperation model, it is necessary to create a new mechanism that is easy to communicate and cooperate. The medical staff should work together to design a treatment plan through regular discussion of diagnosis and treatment. In the communication, the medical staff can better understand the patient's illness and needs, and then give personalized treatment and care plan [7]. Collaboration between health care providers can also improve work efficiency, but also improve the quality of treatment.

To practice the medical cooperation model, it is necessary to establish a scientific

and standardized management process, including the collection and management of patient information, the assessment and monitoring of symptoms, the establishment and mobilization of drugs and treatment programs. By establishing this process, we can improve the treatment effect and quality of care for patients, while reducing medical errors and avoiding the occurrence of repeated treatment. In the management process, the medical staff should pay close attention to the changes in the disease of the patient and change the treatment plan in time according to the need [8].

To practice the medical cooperation model, a sound platform for information exchange and sharing is needed [2]. Medical staff can communicate and discuss patients' symptoms and treatment in real time through electronic medical record systems and telemedicine technology. Healthcare professionals can also use the Internet and mobile technologies to provide remote health consultation and education services to help patients better manage chronic diseases and improve their lifestyle [9].

3.2. Formulation and implementation of customized chronic disease management plan

Customized chronic disease management plan is a key point to deepen and optimize the chronic disease management mode of the elderly at home [10]. These programs are designed to meet the unique needs of elderly patients with chronic disease, improve outcomes, and improve quality of life.

The medical team must understand the physiological condition, lifestyle, material situation and emotional needs of the elderly and grasp the real needs of patients. It also assesses the risk of the disease, the progression of the disease, and even the patient's acceptance of the treatment [11].

When developing a management plan, it is necessary to consider the individual characteristics of the patient, such as age, gender, mood, physiological characteristics, and pay attention to their changes. Changes in the condition may require fine-tuning of the plan. The conditions and needs of elderly patients are often dynamic, and healthcare professionals need to adjust treatment plans and management measures in a timely manner. Patients' preferences and wishes also need to be taken into account and their individual choices and decisions respected [12].

In the execution of the management plan, the medical staff needs to provide a full range of services and support. Including regular medical examination and monitoring, medication guidance and management, daily life care and care. Through various forms of services and support, patients can be helped to better manage chronic diseases and improve their quality of life.

3.3. Regular implementation of family medicine visits

Family medicine visit is another important practice to deeply optimize the management mode of chronic diseases at home for the elderly. Through regular family medicine visits, it is possible to better understand the patient's home environment and lifestyle, provide family medicine services and support, and promote the patient's recovery and health management [13].

The main contents of the family medicine visit include the assessment of the physical condition and living habits of the patient and family members, the investigation of the family environment and social support, and the targeted health education and guidance. Through family medicine visits, healthcare professionals can

better understand the specific needs and problems of patients and develop personalized management plans and service programs.

The regular implementation of family medicine visits is of great significance for the management of chronic diseases at home. Through family medicine visits, patients' health problems and risk factors can be found in time, and corresponding prevention and intervention measures can be taken. Family medicine visit can enhance patients' treatment compliance and self-care ability, improve treatment effect and recovery speed. Family medicine visits can promote good communication and trust between medical staff and patients, establish stable relationship between medical staff and patients, and improve patients' satisfaction with medical services [14].

4. Effects and Challenges After Optimizing the Chronic Disease Management Mode At Home

4.1. The actual impact of the optimized model on patients' quality of life and disease control

The optimization of chronic disease management model for the elderly at home has a practical impact on the quality of life and disease control of patients [15]. Through the practice of medical cooperation mode, patients have received more comprehensive and meticulous medical services, and the development of diseases has been more timely and effective control. Doctors will conduct regular visits to residents' homes and make personalized treatment plans and adjustments according to patients' conditions. Medical staff will provide professional medical guidance and rehabilitation nursing services according to the needs of patients, to promote the rehabilitation of patients and improve the quality of life.

The development and implementation of customized chronic disease management plans also played a positive role. Through comprehensive assessment and monitoring of patients, healthcare professionals can better understand the patient's condition and needs, and develop a corresponding management plan. These programs include medication, diet control, exercise and rehabilitation training. Under the guidance of medical staff, patients can better grasp the treatment methods and lifestyle, effectively control the progress of the disease, improve self-management ability, and thus improve the quality of life.

The regular implementation of family medicine visits also resulted in significant changes for patients after the optimized model. Through family medicine visits, healthcare professionals can more comprehensively understand the patient's living environment and family support, and provide patients with more personalized medical advice and services. Family medicine visits can also help the medical staff to better monitor the changes of the patient's condition, adjust the treatment plan in time, and provide the necessary rehabilitation care and psychological support, so as to better control the development of the disease.

4.2. Analysis of the effect of the optimized mode on the utilization of medical resources

The optimization of chronic disease management mode at home has a positive effect on the utilization of medical resources [16]. Through the medical cooperation mode, the division of labor between doctors and nurses is clear, giving full play to

their respective professional advantages, and improving the utilization efficiency of medical resources and the quality of medical services.

Doctors devote more time and energy to diagnosis and treatment under the cooperative model. Since nurses are responsible for the daily management and care of patients, doctors are able to focus more on diagnosis and treatment, improving the efficiency and accuracy of diagnosis and treatment. In this way, doctors can better cope with the change and complexity of diseases and provide more specialized and sophisticated medical services.

In the optimized model, nurses play an important role. Nurses are responsible for the daily care and management of patients, monitoring patients' living habits and changes in their conditions. Nurses are better able to communicate and communicate with patients and families to provide necessary rehabilitation care and psychological support. In this way, doctors can spend more time on diagnosis and treatment, fully mobilize and utilize the professional abilities of doctors and nurses, and improve the utilization efficiency of medical resources [17].

The optimized management mode also improves the quality and effectiveness of medical services. Through customized chronic disease management plans and family medicine visits, healthcare professionals are able to better understand patients' needs and conditions and provide appropriate medical guidance and rehabilitation care. In this way, medical staff can better meet the needs of patients, provide personalized medical services, improve patient satisfaction and treatment results.

4.3. Problems and challenges in the implementation of chronic disease management for the elderly at home

4.3.1. Lack of comprehensive patient information and medical resource sharing

During the implementation of chronic disease management at home, some patient information may not be comprehensively collected and shared [18,19]. This may lead to health care workers not being able to fully understand important information such as the patient's health status, medical history and treatment process, which may cause problems for the patient's disease management and health guidance. Due to the dispersion of medical resources and information, there is a lack of effective information sharing and collaboration mechanism among relevant medical institutions and professional departments, which makes elderly patients unable to enjoy high-quality medical services and resources.

To solve this problem, it is necessary to establish a sound information sharing system and health records management mechanism. Through the establishment of electronic health records, medical personnel can view the medical information of patients at any time, and timely update and supplement. Establish an information sharing platform across medical institutions to achieve reasonable allocation and invocation of medical resources and improve the convenience and medical effect of patients.

4.3.2. Difficulties in medical cooperation

The management of chronic diseases at home requires close cooperation and coordination among medical staff. In practice, there are some difficulties in the cooperation between medical staff. Because chronic disease management involves multiple areas of expertise, differences in professional background and knowledge

among healthcare workers can lead to difficulties in communication and understanding. Time and resources can be distributed unevenly among health care staff, making it difficult to ensure that each patient receives adequate professional attention and services.

To solve this problem, it is necessary to establish chronic disease management teams and strengthen communication and collaboration between teams. Through regular meetings and case discussions, medical staff can share experiences, exchange problems, and develop unified treatment protocols and management standards.

4.3.3. Insufficient social support and care

The implementation of chronic disease management at home needs social support and family care. In reality there is a lack of social care and support. Some elderly people lack family companionship and care in the process of disease management and rehabilitation, making it difficult to receive timely care and nursing. The lack of social attention and support for the management of chronic diseases at home leads to the insufficiency of related policies and resources.

To address this problem, care and support at the social level need to be strengthened. Social organizations and volunteers can participate in the management of chronic diseases at home for the elderly, providing companionship, care and psychological support for the elderly. The government and relevant departments should pay more attention to and support the elderly, formulate and implement relevant policies, and provide support in terms of medical resources and rehabilitation services.

5. Reflection and Suggestions on the Mode of Medical Cooperation

The professional ability and service attitude of medical staff have a profound impact on the implementation of medical cooperation model. In the face of elderly patients with chronic diseases, medical staff not only need to have solid professional knowledge, but also need to have good communication skills and service attitude. The recommendations for improving the mode of healthcare cooperation are to strengthen professional training and service attitude education for healthcare staff to ensure that they can better provide quality services to elderly patients with chronic diseases [20].

Another problem that needs to be overcome during the implementation of the medical cooperation model is the insufficient participation of family members. Family members play a crucial role in the management of chronic senile disease. The suggestion to improve the mode of medical cooperation is that the enthusiasm of family members should be fully mobilized, so that they become participants and promoters of the management of chronic diseases in the elderly.

Economic factors also have an important impact on the implementation of medical cooperation model. In the current elderly population, many are under economic pressure, which undoubtedly adds to their difficulties in managing chronic diseases. The suggestion for improving the mode of medical cooperation is that medical institutions and the government should initiate financial assistance or medical preferential treatment to reduce the financial burden of patients and let them focus more on disease management rather than financial problems.

6. Conclusions

In view of the increasingly serious aging phenomenon in today's society and the high incidence and long-term characteristics of chronic diseases in the elderly, this study developed a new medical service model - chronic disease management model for the elderly at home. From the perspective of medical cooperation, customized chronic disease management plan and family medicine visit, it has been deeply optimized and adjusted. Studies have shown that the optimized model has significant benefits in improving the disease control effect of patients, improving the quality of life of elderly patients with chronic diseases and reducing the frequency of medical resources use. In the future, a more detailed and humanized research perspective is an important direction to promote the development of China's home chronic disease management service model to a higher level. In addition, with the process of digitalization and intelligence, how to better apply these technologies to chronic disease management is also a direction worth further exploration in the future.

Conflicts of Interest

The author declares that there is no conflict of interest regarding the publication of this article.

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