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A Continuity Of Care Model Based On Family Empowerment Improves The Family's Ability In Managing Hypertension Among Elderly

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Abstract

The aging population phenomenon in Indonesia is one of the focuses of attention because the number of elderly people is increasing, and based on data from the National Socio-Economic Survey (2022) that 10.48% of the population is elderly and in 2030 it is predicted that 1 in 6 of the world's population is elderly (WHO, 2022). Along with increasing age, degenerative diseases also increase, one of which is hypertension which occurs in the age group 31-44 years (31.6%), 45-54 years (45.3%), and 55-64 years (55.2%). Family empowerment is very important because the family is the main support system for the elderly, especially in the early detection and monitoring of risk factors for hypertension in the elderly Through family empowerment-based Continuity of Care (CoC), it is hoped that families will be able to help the elderly manage hypertension problems, to improve the health status and quality of life of the elderly. This study aims to determine the effect of the CoC model based on family empowerment in improving family abilities (knowledge, attitudes, and behavior) to manage hypertension in the elderly. The research was conducted in Denpasar City where the sample size was 62 people, with inclusion criteria, namely the elderly aged 60 years and over, living with family, not bedridden, and not experiencing visual and hearing disabilities. The research design was a quasi experiment with control group design. Data analysis used t-test, Chi-Square, and Multiple Logistic Regression. The results showed that there were significant differences in the ability of families to manage hypertension in the elderly before and after the application of the model in the intervention group, namely knowledge: p-value = 0.019, CI: -2.180-(-0.207); attitude: p-value = 0.002, CI: -4.656-(-1.151); and behavior: p-value = 0.003, CI: -1.519-(-0.352). Likewise, there was a significant difference in the ability of families to manage hypertension in the elderly after the application of the model between the intervention and control groups, namely knowledge: p value=0.001, CI: 0.307-1.177; attitude: p value=0.001, CI: 2.934-8.228; and behavior: p value=0.002, CI: 0.180-0.787. The results of the multivariate test found that length of stay affects family attitudes and occupation on family behavior in managing hypertension in the elderly, apart from the influence of the CoC model. Recommendations: that the CoC model intervention based on family empowerment can be used as a form of intervention in empowering family potential so that they are able to provide assistance to the elderly in the community setting.

Keywords: Continuity of Care; Hypertension; Family Ability; Family Empowerment

INTRODUCTION

The aging population phenomenon is the focus of attention in Indonesia. Data from the National Socio-Economic Survey (2022) showed that 10.48% of the population is elderly. As many as 65.56% of the elderly are classified as young elderly (60-69 years), 26.76 percent of middle elderly (70-79 years), and 7.69 percent of old elderly (80 years and over). By 2030, it is estimated that at least 1 in 6 of the world's population will be elderly (WHO, 2022). The number of people aged 60 years and over is expected to increase from 1.4 billion in 2020 to 2.1 billion in 2050. There are eight provinces that are included in the aging population, namely West Sumatra, Lampung, Central Java, DI Yogyakarta, East Java, Bali, North Sulawesi, and South Sulawesi (BPS, 2022). In Bali Province, the elderly population is currently around 11.58% of the total population. In 2025 it is projected that the number of elderly people will increase to 33.7 million people (11.8%). Increasing the number of elderly people with various health problems is a challenge for Indonesia to prepare healthy, independent, active, productive (SMART), and efficient elderly people in society. One of the problems which is a non-communicable disease, namely hypertension in the elderly is a threat to public health because of its potential to cause various complications. Based on basic health research data (2018), hypertension in Indonesia occurs in the age group 31-44 years (31.6%), 45-54 years (45.3%), and 55-64 years (55.2%) (RI Ministry of Health, 2019). The prevalence of hypertension in the province of Bali is around 29.97%, based on the age group, namely 55-64 years (44.97%), 65-74 years (51.85%), and >75 years (56.21%) (Ministry of Health RI, 2019). The minimum service standards (SPM) in the health sector set by the Denpasar City Health Office mandate that 100% of hypertensive patients receive health services. (Denpasar City Health Office, 2020).

Efforts that have been made by the government in preventing and controlling hypertension include increasing health promotion through communication, information, and education in controlling hypertension with SMART and PATUH behavior; improving community-based hypertension prevention and control with self-awareness through regular blood pressure measurements; as well as strengthening health services, especially hypertension (Biro Komunikasi Kemenkes RI., 2019).

Community empowerment including families in early detection and monitoring of risk factors for hypertension through the Integrated Non-communicable Disease Development Post is also very important and can be held in the community, workplaces, and institutions (Ministry of Health, 2019). This is by the theme of the Health sector on Elderly Day which is commemorated on May 29 2021 in Bali, namely "Elderly Age Happy with Family" because the family is the main support system for the elderly and the family is the best place and source of happiness for the elderly, loves each other, respects and get guidance from parents who have a lot of experience and wisdom (Biro Komunikasi Kemenkes RI., 2021).

Empowerment, namely encouragement or giving strength to families and communities in the form of support, strength, new ideas, and independence in forming new knowledge (Stanhope & Lancaster, 2016). Family empowerment is aimed at the family as the main caregiver for the elderly in managing health problems including the problem of hypertension in the elderly. Family empowerment is an effort to mobilize families to be able to play an active role in identifying problems, planning, and making decisions according to the needs and abilities of the family. The results of Yuniartika and Muhammad's research (2019) found that there was a significant relationship between

family support and the activities of elderly people with hypertension.

Family support is a form of interpersonal relationship that includes attitudes, actions, and acceptance of family members, so that family members feel cared for. Emotional support and support in decision-making by the family are positively related to the level of satisfaction of the elderly (Wang, et.al., 2020). The research results related to family empowerment conducted by Hutagalung, Haryanto, and Fauziningtyas (2020) found a positive relationship between family empowerment in increasing self-efficacy and quality of life for the elderly. The better the pattern of family roles, the better the level of self-efficacy and quality of life for the elderly.

The Continuity of Care model based on family empowerment is one of the strategies to improve the ability of the family both knowledge, attitude, and behavior in caring for the elderly at home, detecting health problems so that action can be taken quickly by utilizing the available health services. This is to the results of Yoon and Kim's research (2020), describing an increase in attitudes, family assessments in elderly care, self-efficacy, and well-being after participating in the Caregiver Empowerment Model (CEM) program for 12 weeks.

The research objective was to determine the effect of the family empowerment-based continuity of care model on the family's ability to manage hypertension among the elderly in Denpasar City.

METHOD

This research was conducted in Denpasar City using a quasi-experimental pre-post test design with a control group design. The research sample is a family with inclusion criteria: 1) Adult to elderly; 2) Living with the elderly; 2) Responsible for caring for the elderly (main caregiver); 4) Willing to be a respondent. The sampling strategy uses the cluster multistage method. The sample size is 62 people (31 intervention groups and 31 control groups). The instrument used to measure the ability of families to care for the elderly was developed by researchers, namely, a knowledge questionnaire consisting of 15 statement items with correct (1) and incorrect (0) answers; The attitude questionnaire consists of 15 statement items with a Likert scale of 0-3 and behavior consists of 15 items with answers done (1) and not done (0). Questionnaire trials were carried out with the results of Cronbach's Alpha reliability test for knowledge (0.803), attitudes (0.786), and behavior (0.838). Data analysis using statistical tests dependent t-test, independent t-test; Chi-Square test, and Multiple Logistic Regression test. All respondents had received an explanation of the research and had given their consent to become respondents by signing an informed consent. Ethical clearance from the Ethics Committee of the Poltekkes Kemenkes Jakarta III No. KEPK-PKKJ3/207/IV/2019.

The application of the Continuity of Care Model through family empowerment is carried out in the intervention group, aimed at families to empower the potential of families as support groups so they can care for elderly people with hypertension. The development of this model is carried out with the following stages of activity: 1) Training for nurses in charge of the elderly health center program on family empowerment in managing hypertension. The involvement of health community nurses is important to continue the interventions carried out if the research has ended. 2) Training for families on hypertension management, early detection, and family assistance to the elderly in managing hypertension.

This training is carried out to provide knowledge and skills so that families can recognize hypertension and make decisions about what actions to take and care for the elderly at home. Families are also trained on how to detect early symptoms of hypertension in the elderly so that they can take action to make referrals to health services; 3) Assistance for the elderly is carried out by the family for 8 weeks (2 times a week) by teaching them a healthy lifestyle so they can prevent relapse and the elderly can report if they experience symptoms or complaints that lead to an increase in blood pressure; 4) Monitoring and evaluation is carried out by the nurse for the family to monitor the family's ability to assist the elderly by using a workbook. This activity is carried out for 8 weeks (1 time a week) through home visits.

The control group was given standard interventions carried out by health community nurses through home visits in the form of education about hypertension

RESULT AND DISCUSSION

Table 1. Distribution of Family Characteristics in Denpasar City

Variable	Intervention Group		Control Group		Total	
	N	%	N	%	N	%
Age						
20-44 Year	20	64.5	13	41.9	33	53.22
45-59 Year	8	25.8	17	54.8	25	40.32
60-74 Year	3	9.7	1	3.3	4	6.46
Sex						
Male	5	16.1	24	77.4	29	46.77
Female	26	83.9	7	22.6	33	53.23
Marital Status						
Married	29	93.5	31	100	60	96.77
Not married	2	6.5	-	-	2	3.23
Education						
< Senior High School	7	22.6	8	25.8	15	24.19
≥ Senior High School	24	77.4	23	74.2	47	75.81
Occupation						
Not Working	13	41.9	1	3.2	14	22.58
Working	18	58.1	30	96.8	48	77.42
Income						
<Provincial Minimum Wage	2	11.1	8	26.7	10	16.13
≥Provincial Minimum Wage	16	88.9	22	73.3	38	83.87
Family Type						
Nuclear Family	2	6.5	2	6.5	4	6.45
Big Family	29	93.5	29	93.5	58	93.55
Family Relations with the Elderly						
Parents/In-laws	25	80.6	31	100	56	90.32
Grandma/Grand father	2	6.5	-	-	2	3.22
Husband/Wife	4	12.9	-	-	4	6.46

Variable	Intervention Group		Control Group		Total	
	N	%	N	%	N	%
Length of Stay with the Elderly						
1. ≤ 2 year	24	77.4	6	19.4	30	48.39
2. > 2 year	7	22.6	25	80.6	32	51.61

Family characteristics showed that the majority were adults (20-44 years) in the intervention group and pre-elderly (45-59 years) in the control group, the majority were female in the intervention group, while the majority in the control group were male; marital status in both groups the majority are married; majority education level above high school; the majority work with income above Provincial Minimum Wage; Major family type is extended family; The majority of family relationships are as parents or in-laws in both groups and the length of stay with the elderly is the majority ≤ 2 years in the intervention group while in the control group, the majority is > 2 years.

Table 2. Differences in Family Capabilities (Knowledge, Attitudes, and Behavior) before and after the CoC Model-Based Family Empowerment intervention in the intervention and control groups in Denpasar City

Variable	Groups	Mean	SD	95% CI	t	P value*
Family Capabilities						
Knowledge	**Intervention Group** Before After Difference	11.55 12.74 1.19	1.877 1.983	2.180-(-0.207)	-2.472	**0.019**
	Control Group Before After Difference	13.42 13.26 0.16	1.259 0.631	-0.274-0.596	0.757	0.455
Attitude	**Intervention Group** Before After Difference	32.48 35.39 2.91	4.864 7.214	-4.656-(-1.151)	-3.384	**0.002**
	Control Group Before After Difference	30.97 29.97 1.00	5.301 2.213	-0.851 -2.851	1.103	0.279
Behavior	**Intervention Group** Before After Difference	13.42 14.35 0.93	1.285 0.755	-1.519-(-0.352)	-3.275	**0.003**
	Control Group Before After Difference	14.10 13.94 0.16	0.870 0.574	-0.194-0.517	0.926	0.362

**dependent t-test*

The results of the analysis showed that there were significant differences in family knowledge, attitudes, and behavior in caring for the elderly with hypertension in the intervention group before and after the intervention of the Family Empowerment-Based CoC model in Denpasar City (p-value ≤ 0.05), while in the control group, there was no significant difference in knowledge, attitude and family behavior in caring for elderly people with hypertension (p-value≥ 0.05).

The results showed that the application of the CoC model based on family empowerment can improve family abilities (knowledge, attitudes, and behavior) in managing hypertension in the elderly.

The increase in the average value of knowledge in the intervention group before and after the implementation of the CoC model was 1.19 points. This increase occurred because of the provision given to families about hypertension and how to manage it as well as early detection for making the right decisions so that families can recognize and make decisions about hypertension care in the elderly. This is consistent with the function of the family in health care, namely being able to recognize and make decisions about health problems experienced by family members (Friedman & Bowden, 2010). Also supported by the results of Mulia's research (2018) that there is a significant relationship between the family's ability to recognize the problem of hypertension in the elderly and the incidence of hypertension in the elderly.

In addition to debriefing, nurses also monitor every week by evaluating family knowledge about hypertension which helps families to carry out consultations if something is still not understood. This increases the confidence of the family in caring for the elderly with hypertension. The increase in family knowledge is also related to the level of education, the majority of which are high school and above, so that it is easier to absorb the knowledge conveyed. Education is one of the factors that contribute to family knowledge. This is the opinion of Notoatmodjo (2014) that knowledge can be influenced by internal factors including education, employment, age, and information. The results of Mustika, Sukmawati & Suhendar's research (2020), found that most family's knowledge about hypertension in the elderly (62.1%) had sufficient knowledge so that it became a provision for families in caring for elderly people with hypertension.

This Continuity of Care model involves the role of the family in the early detection of hypertension so that appropriate action can be taken. Through early detection using a workbook, families can report symptoms that arise to nurses so that cases can be referred to the nearest service. This is to the Regulation of the Minister of Health of the Republic of Indonesia, (2016), that when self-medication methods have not succeeded in eliminating health complaints, the elderly will visit healthcare facilities for treatment. Health service planning must be designed according to the condition of the elderly to prevent complications.

The increase in the average value of family attitudes in the intervention group before and after implementing the CoC model based on family empowerment was 2.91 points. This may be related to the family's sense of responsibility to care for the elderly so that a sense of empathy and love and respect for parents grows. From the results of the study, it was found that the majority of family relationships with the elderly were as parents or in-laws. Likewise, from the type of family, the majority found the type of extended family where the elderly live with family members, whether children, grandchildren, or in-laws. This type of extended family is characteristic of Indonesian culture which respects parents for their experience and wisdom.

Improving family attitudes in caring for elderly people with hypertension is also related to increasing family knowledge about hypertension. By understanding the management of hypertension and early detection, families feel more confident in caring for the elderly. This is to the results of research by Wibowo and Zen (2021) that there is a significant relationship between the level of family knowledge and family attitudes about treating rheumatoid arthritis in the elderly. The existence of the family as the main support system for the

elderly is needed in assisting the elderly with hypertension. Family empowerment through the CoC model is aimed at building relationships of mutual love, and respect, and meeting the needs of the elderly so that the elderly feel needed and are efficient in the family environment. This is consistent with the results of qualitative research by Sakanashi, Fujita, and Konno (2021) that the empowerment component includes proactive aspects of care, creating respectful relationships, building relationships based on mutual understanding, and understanding the social aspects of the elderly.

The increase in the average value of family behavior in the intervention group before and after the implementation of the family empowerment-based CoC model was 0.93 points. Changes in family behavior require quite a long time, let alone caring for the elderly with health problems, special skills are needed in dealing with the elderly. This may cause the average value of behavior improvement to be the smallest compared to the increase in the average value of family knowledge and attitudes before and after the implementation of the CoC model based on family empowerment.

Good family health duties can be said to be good family behavior in improving the mental health of family members. The results of Cheng's research (2017) found that good family functioning has a significant effect on the mental health of family members both living in urban and rural areas.

Family empowerment is a mechanism for changing abilities in the family which has a positive impact on nursing plans and health promotion actions and is the culture in the family that influences treatment actions and family development (Azza & Setyowati, 2015). Efforts to empower families can be done by applying skills and increasing competence in the context of changes in the family. This is done through briefing given to families about early detection and treatment of hypertension in the elderly so that families have competence in caring for elderly people with hypertension. According to Uchiyama, Tsukada, and Sakuraba (2015), families believe in their ability to solve problems independently, provide opportunities for family members to discover their capacities, provide opportunities for interaction, and provide support in increasing their independence. Through interactions that families carry out with the elderly on an ongoing basis and by increasing family knowledge in caring for the elderly, the health behavior of both families and the elderly increases. The elderly become obedient and adopt healthy behaviors so they can maintain stable blood pressure. The role of the family is very important in helping the elderly to improve their health behavior so that their quality of life increases. This is to the results of research by Fadhlia and Sari (2021), finding that there is a relationship between the role of the family and the quality of life of the elderly.

Table 3. Differences in Family Capabilities (Knowledge, Attitudes, Behaviors) After the intervention of the Family Empowerment-Based CoC Model between the Intervention and Control Groups

Variable	Groups	N	Mean	SD	95% CI	t	P value*
Knowledge	Intervention	31	14.00	1.033	0.307-1.177	3.414	**0.001**
	Control	31	13.26	0.631			
Attitude	Intervention	31	35.55	7.028	2.934-8.228	4.217	**0.001**
	Control	31	29.97	2.213			
Behavior	Intervention	31	14.42	0.620	0.180-0.787	3.188	**0.002**
	Control	31	13.94	0.574			

**Independent t-test*

The results of the analysis showed that there were significant differences in family knowledge, attitudes, and behavior in caring for the elderly with hypertension between the intervention group and the control group after the intervention of the Family Empowerment-Based CoC Model in Denpasar City, with a $p<0.05$.

2. Effect of family characteristics on the family ability to care for elderly with hypertension

The selection of candidate multivariate variables is done by associating all independent variables with the dependent variable using the chi-square test. Independent variables that are candidates for inclusion in the multivariate model are those that meet the p-value requirements of less than 0.250. The selection results can be seen in the following table.

Table 4. Results of Candidate Selection Effect of Family Characteristics on Families' Ability to Caring for Elderly with Hypertension

No	Independent Variable	Dependent Variable		
		Knowledge	Attitude	Behavior
1	Sex	0.435	**0.170**	**0.188**
2	Occupation	**0.024**	0.316	**0.034**
3	Income	**0.074**	0.359	0.503
4	Length of Stay with the Elderly	**0.204**	**0.072**	0.280
5	Family Relations with the Elderly	**0.167**	0.366	**0.095**

Based on the results of an analysis of the dependent variable knowledge, 4 independent variables qualify for entry into the multivariate model, namely work, income, length of stay with the elderly, and family relationships with the elderly; 2 independent variables meet the requirements for entering the model, namely gender and length of stay with the elderly; while for the dependent variable behavior, 3 variables meet the requirements to enter the model, namely gender, occupation, and family relationship with the elderly.

Table 5. Final Model: Effect of Family Characteristics on Families' Ability to Caring for Elderly with Hypertension

Variable	B	SE	Wald	p-value*	Exp (B)	95%CI
Attitude						
Length of stay	-1.088	0.536	4.127	**0.042**	0.337	0.118-0.962
Constant	1.282	0.823	2.426	0.119	3.604	
Behavior						
Family work	-1.501	0.640	5.498	**0.019**	0.223	0.064-0.782
Constant	1.788	1.133	2.490	0.115	5.980	

* *Multiple Logistic Regression Test*

The results of multivariate analysis showed that there was no effect of family characteristics on family knowledge in caring for the elderly with hypertension, however, it was found that there was an effect of length of stay in the family on family attitudes in caring for elderly hypertension and family work on family behavior in caring for elderly people with hypertension. It can be concluded that apart from the intervention of the CoC model based on family empowerment, there are variables of the length of stay and work that affect the family's ability to care for elderly people with hypertension in Denpasar City.

The results of the study found that there was an influence on family characteristics, namely the length of time the family lived with the elderly and family work on their ability to manage hypertension in the elderly, apart from the influence of the Continuity of Care model intervention. The majority found the length of stay of families with the elderly ≤ 2 years where families have not experienced saturation (burden) in caring for the elderly. It is possible that families can still adapt to the conditions of the elderly, can accept changes that occur in the elderly, and feel more empathetic it increases the enthusiasm of the family to care for the elderly. Supported by the research results of Dharma, et.al (2021) that the Caregiver Empowerment Program Based on the Adaptation Model (CEP-BAM) intervention is effective in increasing adaptive coping strategies and reducing the burden on families in caring for elderly stroke.

Work influences family behavior in caring for the elderly with hypertension. The results of the study found that the majority of families were working and female. Meliza, Iskandar, and Soemarwoto (2019) said that working women have a strong potential to increase family economic income. If it is related to Balinese culture, working women are common in life who have multiple roles and can be responsible for their families and the community environment. Working families will spend less time interacting with the elderly which will affect their behavior in caring for the elderly with hypertension. When it is related to the position of women in Bali, Lestari et al (2016) state that Balinese women have a respectable position in society. Women play a good role in the domestic sphere and take a meaningful role in social life. Women will be a measure of the success of a family and will carry it to the next generation. This certainly has an impact on his behavior in caring for family members who have health problems, including the elderly. Even though the interaction time is limited because they have to work, the family still pays attention to the elderly.

CONCLUSION

The application of the Family Empowerment-Based Continuity of Care Model has proven to be effective in increasing the ability of families to manage hypertension in the elderly from both the knowledge, attitude, and behavioral aspects. This helps families in strengthening family functions in maintaining the health of their family members. The implication is that it can be applied in primary care as an intervention strategy for family empowerment so that family members can become independent in dealing with their health problems. It is necessary to strengthen the family as the main caregiver by providing regular training so that they can care for the elderly with various health problems.

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