

Original Article

Patient Confidence in Long-Term Care Plans for Multimorbidity Management: A Qualitative Descriptive Study

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ABSTRACT

Background: Multimorbidity creates substantial challenges for long-term care because patients must manage multiple medicines, appointments, monitoring tasks, lifestyle recommendations, and disease-specific instructions. Although care plans are intended to improve coordination and continuity, patients may not experience them as understandable, feasible, or trustworthy in daily life. **Objective:** This study explored how adults with multimorbidity described the factors that strengthened or weakened their confidence in long-term care planning. **Methods:** A qualitative descriptive design was used. Twelve anonymized participant profiles from adults with two or more chronic conditions and experience of long-term care planning, medication planning, review planning, or coordinated management advice were analyzed using reflexive thematic analysis. The analysis was informed by treatment burden, cumulative complexity, and person-centred integrated care concepts. **Results:** Six interrelated themes were generated: fragmented care and unclear plan ownership, continuity and relational trust, treatment workload and limited capacity, unclear priorities and competing disease advice, family support and social negotiation, and follow-up reliability as evidence of care commitment. Confidence increased when plans were clear, coordinated, realistic, reviewed, and connected to a named professional or responsible team. Confidence decreased when advice was fragmented, workload was excessive, priorities were unclear, family support became controlling, or follow-up was unreliable. **Conclusion:** Patient confidence in multimorbidity care planning depends on relational continuity, practical feasibility, coordinated responsibility, explicit prioritization, respectful family involvement, and reliable follow-up. Care planning should be treated as an ongoing patient-centred process rather than a static document. **Keywords:** Multimorbidity, patient confidence, long-term care plan, treatment burden, care coordination, shared decision-making, qualitative study.

EDITORIAL INFORMATION

Author Contributions: Concept: MY; Literature Review: ANN; Drafting: TAM; Critical Revision and Final Approval: MY, ANN, TAM.**Ethical Approval:** Universitas Prima Indonesia**Informed Consent:** Written informed consent was obtained from all participants**Conflict of Interest:** The authors declare no conflict of interest; **Funding:** No external funding; **Data Availability:** Available from the corresponding author on reasonable request; **Acknowledgments:** N/A.

INTRODUCTION

Multimorbidity, commonly defined as the coexistence of two or more chronic health conditions in the same individual, has become an increasingly important challenge for contemporary health systems because it requires patients to manage multiple medicines, appointments, monitoring activities, lifestyle recommendations, and disease-specific instructions over prolonged periods. For adults living with combinations of diabetes, hypertension, cardiovascular disease, chronic respiratory disease, kidney disease, chronic pain, mental health problems, frailty, or other long-term conditions, care is rarely experienced as a single coordinated pathway. Instead, patients often encounter separate clinical encounters, fragmented messages, and condition-specific priorities that must be interpreted and reconciled in everyday life. International evidence shows that multimorbidity is associated with increased service use, complex treatment demands, and greater vulnerability to fragmented care, making long-term

care planning a central concern for patient safety, treatment adherence, and person-centred chronic disease management (1).

The increasing burden of noncommunicable diseases further strengthens the need to understand how patients experience long-term care planning. Chronic illnesses frequently coexist and interact, yet clinical recommendations are still often organized around single-disease pathways. When each condition is managed separately, patients may receive multiple prescriptions, monitoring instructions, lifestyle targets, and follow-up schedules without a clear explanation of how these components fit together. This can leave patients uncertain about which recommendations should take priority, who is responsible for coordinating the overall plan, and how they should respond when advice for one condition appears to conflict with advice for another. In this context, patient confidence is not simply an emotional response or general satisfaction with care; it reflects whether patients understand the plan, believe it is clinically and personally appropriate, consider it feasible within their daily capacity, and trust that professionals will review and adjust it over time (2).

Long-term care plans are intended to support continuity, shared goals, coordinated treatment, and safer decision-making across chronic conditions. However, the existence of a written plan does not necessarily mean that patients experience care as coherent, manageable, or trustworthy. A plan documented in a clinical record may appear complete from a service perspective but remain difficult to implement at home if patients are unsure why medicines have been changed, how to manage side effects, when review will occur, which clinician to contact, or how to balance medical advice with work, family responsibilities, transport limitations, finances, fatigue, and health literacy. Patient confidence in care planning can therefore be understood as a practical indicator of whether multimorbidity care is usable in real life, rather than merely whether a plan has been formally produced (3).

Current guidance on multimorbidity increasingly emphasizes person-centred care, medication review, shared decision-making, prioritization, and treatment burden awareness. These principles are particularly important because patients with multimorbidity are often required to perform substantial healthcare work outside clinical settings, including organizing appointments, remembering instructions, monitoring symptoms, taking medicines correctly, adjusting routines, communicating with family members, and seeking clarification when recommendations are unclear. When the workload generated by care exceeds the patient's available capacity, even clinically appropriate advice may become difficult to follow. Confidence in a care plan is therefore shaped not only by the perceived competence of individual clinicians but also by the extent to which the overall plan reduces confusion, fits the patient's priorities, and provides realistic support for implementation (4).

Integrated care policy also recognizes that chronic disease management requires coordination across primary care, specialist services, nursing, pharmacy, community support, and informal caregiving networks. From the patient's perspective, integration becomes meaningful when someone appears to hold responsibility for the whole picture, medicines are reviewed in relation to all conditions, test results are explained, follow-up is reliable, and patients know what to do if symptoms, side effects, or circumstances change. A named professional or identifiable care team may therefore act as a source of relational trust, while unreliable follow-up or repeated retelling of medical history may signal fragmentation. These everyday experiences can strongly influence whether patients regard a long-term care plan as dependable, flexible, and safe (5).

Despite the growing literature on multimorbidity, treatment burden, care coordination, and shared decision-making, less is known about how patients themselves judge whether long-term care plans are understandable, feasible, trustworthy, and responsive to changing circumstances. Existing care-planning approaches often focus on documentation, clinical targets, and service processes, whereas patients may evaluate care plans through more practical and relational criteria, including clarity of ownership, continuity, workload, prioritization across conditions, family involvement, and follow-up reliability. Exploring these dimensions is important because low confidence may not indicate patient resistance or

poor motivation; it may instead reveal that the plan has not been sufficiently coordinated, explained, reviewed, or adapted to the patient's everyday capacity.

This qualitative descriptive study explored how adults with multimorbidity described the factors that strengthened or weakened their confidence in long-term care planning. The study focused on patient comprehension, trust, perceived feasibility, treatment workload, communication with professionals, shared decision-making, family involvement, and follow-up reliability. The objective was to describe how patients interpret confidence and uncertainty in multimorbidity care planning and to identify practical features of care plans that may make complex long-term care more understandable, manageable, and trustworthy.

MATERIALS AND METHODS

A qualitative descriptive design was used to explore how adults with multimorbidity understood and evaluated their confidence in long-term care planning. This design was appropriate because the study sought to generate a practice-oriented account of patient experiences in accessible language while remaining close to participants' descriptions of care, rather than developing a formal explanatory theory or measuring confidence quantitatively. Qualitative description is particularly suitable for health services research questions where the aim is to understand how patients interpret care processes, identify practical barriers, and generate findings that can inform clinical communication, care coordination, and service improvement (21,22).

The study was conducted among adults aged 21 years and above who were living with two or more chronic health conditions and had experience of a long-term care plan, medication plan, review plan, or coordinated management advice related to ongoing multimorbidity management. For the purposes of this study, a long-term care plan was operationally defined as any written, verbal, or clinically communicated plan intended to guide continuing management of multiple chronic conditions, including medication instructions, follow-up arrangements, monitoring advice, lifestyle recommendations, safety-netting instructions, or coordinated guidance across more than one condition. Participants were purposively selected to provide variation in condition combinations, perceived confidence in care planning, trusted sources of care information, and main barriers to plan implementation. The final sample consisted of 12 anonymized participant profiles coded as P01 to P12, representing adults with different combinations of chronic conditions, including diabetes, hypertension, cardiovascular disease, chronic respiratory disease, arthritis, chronic pain, kidney disease, stroke history, depression, anxiety, obesity, sleep apnoea, frailty, and polypharmacy.

Purposive sampling was used because the objective was not statistical representativeness but the inclusion of participants whose experiences could provide rich insight into confidence, uncertainty, treatment workload, continuity, and coordination in multimorbidity care. The sample was considered adequate for qualitative descriptive interpretation because the research question was focused, the participant group was specific, the data were directly related to the phenomenon of interest, and recurring patterns were identified across participants with different confidence levels and care-planning barriers. The sampling strategy also supported variation in trusted sources, including general practitioners, nurses, pharmacists, specialist nurses, family caregivers, online portals, clinic staff, neighbours, and family doctors, allowing the analysis to examine how confidence was shaped by both professional and informal sources of support.

Data were generated from anonymized semi-structured interview accounts and participant profile data. The interview accounts focused on how participants understood their care plans, how they interpreted advice from different professionals, how they managed medicines and appointments, how family members influenced plan implementation, how they responded to conflicting recommendations, and how follow-up arrangements affected their confidence. The interview guide was informed by the study objective, multimorbidity care literature, the Cumulative Complexity Model, Burden of Treatment Theory, and person-centred integrated care principles. It covered care-plan comprehension, communication with professionals, perceived ownership of the plan, confidence in follow-up, medication burden, appointment

workload, monitoring demands, family support, competing disease advice, and participant suggestions for improving care planning. Semi-structured interviewing was appropriate because it allowed common areas of inquiry to be addressed across participants while also permitting participants to elaborate on experiences, concerns, and priorities that were personally important (23).

All participant material was anonymized before analysis. Codes P01 to P12 were used in place of names, and identifying details related to clinicians, family members, workplaces, and care locations were removed. The analytic dataset consisted of interview accounts, participant profile characteristics, confidence status, trusted source of care information, main confidence barrier, and a thematic coding matrix. The coding matrix was used to compare how confidence was strengthened or weakened across different care-planning contexts, including fragmented care, continuity, treatment workload, unclear prioritization, family involvement, and follow-up reliability. Reporting was guided by qualitative reporting principles emphasizing transparency of design, context, sampling, data generation, analysis, and interpretation (24).

Reflexive thematic analysis was used to analyse the data. The analysis began with repeated reading of participant accounts to develop familiarity with the content and to identify initial meanings related to confidence, uncertainty, trust, care-plan ownership, treatment burden, and follow-up. Initial codes were generated across the dataset and then compared within and across participant profiles. Coding was both deductive and inductive. Deductive coding was informed by prior concepts from multimorbidity care, treatment burden, cumulative complexity, continuity, shared decision-making, and integrated care, while inductive coding was used to retain patterns that emerged directly from participant accounts. Candidate themes were developed by grouping related codes, checking their coherence against the data, refining boundaries between themes, and naming themes in a way that captured both descriptive content and analytic meaning (25).

The analysis focused on identifying how patients judged whether a care plan was understandable, realistic, coordinated, personally relevant, and reviewable over time. Particular attention was given to the relationship between participant confidence and six recurring areas: visible plan ownership, relational continuity, treatment workload, prioritization across conditions, family negotiation, and reliability of follow-up. Themes were retained when they were supported by repeated patterns across participant accounts and when they explained meaningful variation in confidence status. Participant quotations were used to preserve the link between interpretation and the original accounts, and the final themes were reviewed to ensure that they reflected the dataset rather than only the theoretical frameworks used to sensitize the analysis.

Trustworthiness was addressed through attention to credibility, transferability, dependability, and confirmability. Credibility was supported by maintaining a close connection between participant accounts, coding, theme development, and illustrative quotations. Transferability was supported by presenting participant profiles, condition combinations, confidence status, trusted sources, and main confidence barriers so that readers could judge the relevance of findings to other multimorbidity care contexts. Dependability was supported by using a systematic coding and theme-development process, while confirmability was strengthened by separating participant evidence from analytic interpretation and by treating low confidence as a potential signal of care-plan design, communication, coordination, or workload problems rather than as a marker of patient failure (26).

Ethical approval was obtained from Universitas Prima Indonesia. Written informed consent was obtained from all participants before inclusion. The study was conducted in accordance with ethical principles for research involving human participants, including respect for autonomy, confidentiality, privacy, and non-maleficence. Because the study addressed potentially sensitive experiences related to illness, dependence, family support, uncertainty, and difficulty managing treatment workload, all findings were presented anonymously and without identifiable personal or clinical details. Data were handled confidentially, and reporting emphasized care-planning processes rather than individual blame or non-adherence (27,28).

RESULTS

The analysis generated six interrelated themes explaining how adults with multimorbidity developed, maintained, or lost confidence in long-term care planning. Confidence was not expressed as simple trust in the existence of a written plan. Rather, participants judged care plans according to whether the plan was understandable, coordinated, realistic, personally relevant, supported by family or professionals, and linked to reliable follow-up. Some participants trusted an individual clinician but remained uncertain about the overall plan, while others accepted the need for medicines but lacked confidence in lifestyle advice, appointment schedules, monitoring tasks, or review arrangements. Across the dataset, care-plan confidence was strongest when participants could identify a professional or team responsible for the whole plan, understood how different recommendations fitted together, felt able to carry out the required workload, and believed that the plan would be reviewed when circumstances changed.

Table 1. Participant Profiles and Care-Plan Confidence

| Participant Code | Participant Profile | Care-Plan Confidence | Primary Trusted Source | Main Confidence Barrier |
|------------------|--|------------------------|------------------------|---------------------------------------|
| P01 | Older adult with diabetes and hypertension | Moderate confidence | GP nurse | Needed clearer medication explanation |
| P02 | Middle-aged worker with heart disease and arthritis | Low confidence | Cardiologist | Conflicting activity advice |
| P03 | Retired patient with COPD, diabetes, and anxiety | Uncertain | Family doctor | No named plan owner |
| P04 | Caregiver-patient with kidney disease and hypertension | Conditional confidence | Pharmacist | High medication workload |
| P05 | Older adult with heart failure and diabetes | High confidence | Regular GP | Continuity and follow-up |
| P06 | Patient with stroke history and depression | Low confidence | Daughter | Difficulty understanding priorities |
| P07 | Self-employed patient with asthma and hypertension | Uncertain | Clinic receptionist | Appointment and income burden |
| P08 | Older woman with arthritis, diabetes, and chronic pain | Moderate confidence | Community nurse | Needed family support |
| P09 | Migrant patient with hypertension and chronic pain | Low confidence | Neighbour and GP | Language and navigation barriers |
| P10 | Retired teacher with heart disease and kidney disease | High confidence | Specialist nurse | Clear review plan |
| P11 | Middle-aged patient with obesity, diabetes, and sleep apnoea | Uncertain | Online portal and GP | Digital and information overload |
| P12 | Older adult with frailty and multiple medicines | Conditional confidence | Family caregiver | Fear of side effects |

The participant profiles showed variation in confidence status, condition combinations, trusted sources, and barriers to plan implementation. Higher confidence was seen where participants described continuity, clear review arrangements, and recognizable professional responsibility for the care plan. Lower or uncertain confidence was associated with fragmented guidance, unclear prioritization, language or navigation barriers, digital overload, appointment burden, medication workload, and fear of side effects. Participants with conditional confidence did not reject their plans, but their confidence depended on whether medicines, family support, and follow-up arrangements remained manageable and responsive.

The first theme was fragmented care and unclear plan ownership. Participants described receiving separate pieces of advice from different professionals without always knowing how these recommendations fitted into one coherent plan. This did not reflect distrust of specialist expertise; rather, it reflected uncertainty about whether anyone was responsible for integrating advice across conditions. For participants with multiple appointments, medicines, and disease-specific instructions, repeated explanations of medical history during consultations signalled weak continuity and reduced confidence in the overall plan. P03 captured this concern by stating, “Everyone tells me one part, but no one tells me the whole picture.” This theme showed that confidence was weakened when patients became the default coordinators of complex care without sufficient clinical guidance or a named professional responsible for the whole plan.

The second theme was continuity and relational trust. Participants expressed stronger confidence when they interacted with a clinician or care professional who knew their history, remembered previous decisions, and could explain why the plan had changed over time. Continuity was not limited to seeing the same professional at every visit; it also included the feeling that information was carried forward and that current recommendations were connected to earlier problems, preferences, and treatment experiences. P05 described this reassurance by stating, “Because they know me, I feel the plan is not just copied from a book.” This theme indicated that confidence was strengthened when care planning felt personalized, cumulative, and responsive rather than generic or repeatedly restarted.

Table 2. Thematic Findings on Patient Confidence in Long-Term Care Planning

| Theme | Key Codes | Analytical Meaning | Illustrative Quotation |
|---|--|---|---|
| Fragmented care and unclear plan ownership | Unclear coordinator; repeated history; specialist separation | Patients lacked confidence when no professional appeared responsible for integrating advice across conditions. | P03: “Everyone tells me one part, but no one tells me the whole picture.” |
| Continuity and relational trust | Known clinician; remembered history; regular review | Confidence improved when patients were known over time and did not need to restart explanations at each contact. | P05: “Because they know me, I feel the plan is not just copied from a book.” |
| Treatment workload and limited capacity | Medicine burden; fatigue; appointment work; monitoring tasks | Plans lost credibility when the practical demands of care exceeded the patient’s capacity. | P04: “The tablets are not the only burden. Remembering everything is also work.” |
| Unclear priorities and competing disease advice | Conflicting instructions; priority confusion; uncertain trade-offs | Patients needed help deciding which advice mattered most when recommendations for different conditions conflicted. | P02: “One doctor says walk more, another says rest the knee. I need someone to choose with me.” |
| Family support and social negotiation | Help; pressure; dependency; shared responsibility | Family involvement increased confidence when it supported the patient but reduced ownership when it became controlling. | P08: “My daughter helps, but sometimes she takes over and I feel it is not my plan.” |
| Follow-up reliability as evidence of care commitment | Review dates; call back; test results; safety net | Confidence depended on whether patients believed that the plan would be reviewed, adjusted, and supported over time. | P10: “The plan works because I know when they will call and what to do before then.” |

The third theme was treatment workload and limited capacity. Participants did not evaluate care plans only by their clinical content; they also judged whether the work required to follow the plan was manageable. Medicines, symptom monitoring, appointments, transport, financial costs, fatigue, memory demands, and family responsibilities all shaped confidence. A plan could appear clinically appropriate but still feel unrealistic if it required more work than the patient could absorb in daily life. P04 emphasized this broader workload by stating, “The tablets are not the only burden. Remembering everything is also work.” This theme showed that confidence decreased when care plans added tasks without accounting for the patient’s physical, emotional, cognitive, social, and practical capacity.

The fourth theme was unclear priorities and competing disease advice. Participants described receiving recommendations that were reasonable in relation to one condition but difficult to reconcile with another. Advice to increase physical activity, restrict activity, change diet, monitor symptoms, or attend multiple appointments could become confusing when no one explained what should take priority. P02 illustrated this uncertainty by stating, “One doctor says walk more, another says rest the knee. I need someone to choose with me.” This theme demonstrated that patients did not always need more information; they needed support to interpret trade-offs, identify priorities, and understand why some goals should be emphasized over others at particular points in time.

The fifth theme was family support and social negotiation. Family members helped participants remember medicines, travel to appointments, understand instructions, monitor symptoms, and feel reassured. For some participants, family involvement made the plan more practical and increased confidence. However, family involvement could also create tension when relatives became overly controlling or made decisions on behalf of the patient. P08 described this balance by stating, “My daughter helps, but sometimes she takes over and I feel it is not my plan.” This theme showed that family support improved confidence when it preserved patient autonomy, but reduced confidence when the patient felt displaced from decision-making.

The sixth theme was follow-up reliability as evidence of care commitment. Participants were more confident when review arrangements were clear, when they knew when they would be contacted, when

test results would be discussed, and what they should do before the next appointment if symptoms or side effects occurred. Follow-up was interpreted as evidence that the plan was active, monitored, and adjustable rather than a one-time document or instruction. P10 stated, “The plan works because I know when they will call and what to do before then.” This theme showed that reliable follow-up converted care planning from an administrative exercise into an ongoing relationship of responsibility and safety.

Overall, patient confidence in long-term care planning was shaped by the interaction of coordination, continuity, workload, prioritization, family involvement, and follow-up. Confidence was strongest when participants could recognize a plan owner, understand the relationship between medicines and lifestyle recommendations, negotiate conflicting priorities, involve family members without losing ownership, and rely on clear review arrangements. Confidence was weakest when care felt fragmented, excessive, unexplained, unsupported, or disconnected from everyday life. These findings suggest that care-plan confidence in multimorbidity is best understood as a practical and relational judgement about whether complex care is coherent, manageable, and responsive over time.

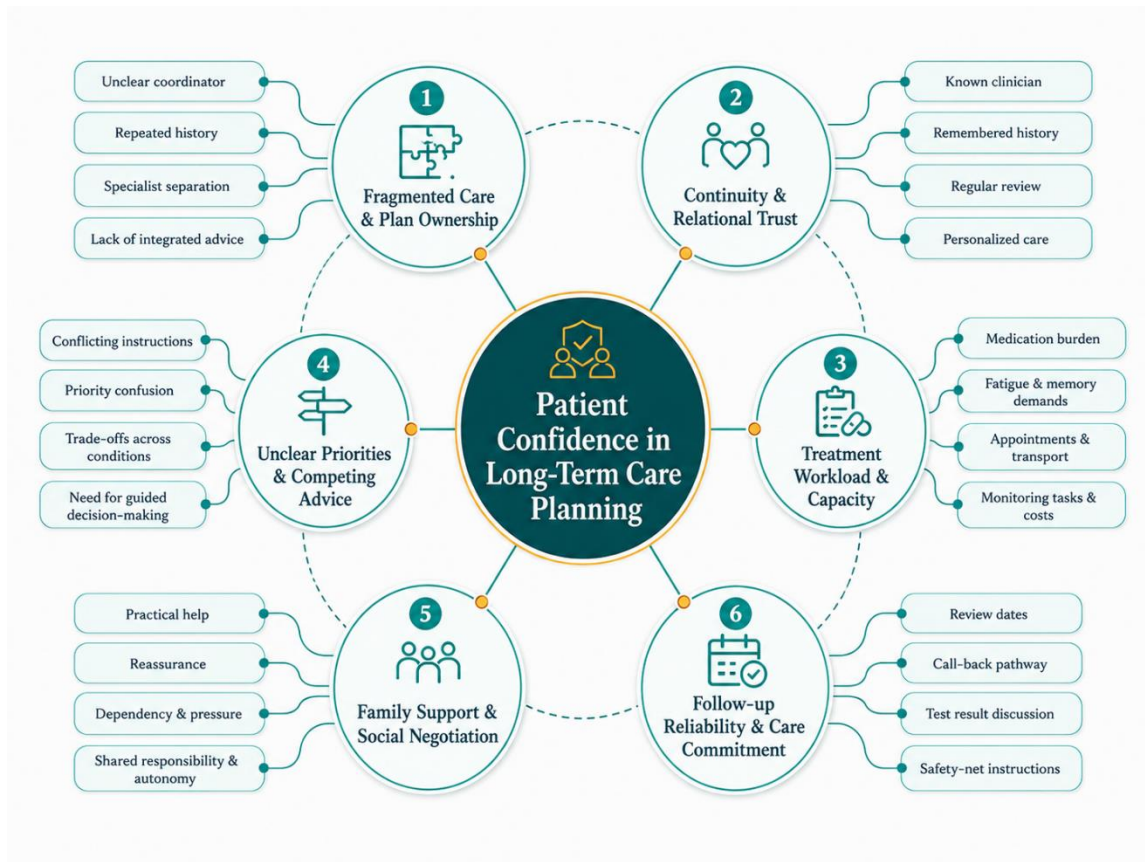


Figure 1 Graphical Illustration of Themes

DISCUSSION

This qualitative descriptive study explored how adults with multimorbidity understood and evaluated their confidence in long-term care planning. The findings show that confidence was not generated by the mere existence of a written or verbally communicated plan. Instead, patients developed confidence when the plan was understandable, coordinated, realistic, personally relevant, and visibly supported through continuity, review, and professional responsibility. Across the six themes, patient confidence emerged as a relational and practical judgement: participants trusted care plans when they could identify who was responsible for the whole plan, understood why recommendations were being made, believed that the required workload was manageable, and expected that the plan would be reviewed when symptoms, medicines, priorities, or family circumstances changed.

The theme of fragmented care and unclear plan ownership supports existing evidence that multimorbidity is difficult to manage when care remains organized around separate diseases rather than around the

patient's overall situation. Patients in this study did not reject specialist expertise, but they were less confident when advice arrived in disconnected parts and no professional appeared responsible for integrating the whole picture. This finding is consistent with multimorbidity guidance emphasizing the need to move beyond single-condition decision-making and to consider interactions between diseases, treatments, patient priorities, and healthcare workload (3,5). For participants, plan ownership was not simply an administrative designation; it was a visible sign that someone understood how multiple recommendations related to one another. When ownership was unclear, patients became the default coordinators of complex care despite having limited clinical knowledge, time, energy, or confidence to reconcile competing instructions.

Continuity and relational trust were central to confidence because patients interpreted remembered history, regular review, and personalized explanation as evidence that the plan had been adapted to their circumstances rather than copied from a generic disease pathway. This finding aligns with literature showing that experienced continuity is particularly important for patients who see multiple clinicians and need reassurance that decisions are connected across time and care settings (11,12). In this study, continuity did not require absolute dependence on one professional; rather, it required informational and relational coherence. Patients were more confident when professionals remembered previous decisions, explained changes, and linked current recommendations with past experiences. This suggests that continuity should be treated as a core mechanism of care-plan confidence in multimorbidity rather than as a desirable but optional feature of service delivery.

Treatment workload and limited patient capacity represented one of the strongest threats to confidence. Participants judged care plans not only by whether recommendations were medically appropriate but also by whether they could realistically perform the work required. Medicines, appointments, transport, monitoring, memory demands, fatigue, costs, and family responsibilities all shaped whether a plan felt manageable. This finding is directly supported by Burden of Treatment Theory and the Cumulative Complexity Model, both of which emphasize that healthcare transfers substantial work to patients and that adherence depends on the balance between workload and capacity (7,8). The results also support empirical work showing that patients with chronic conditions experience medication management, administrative tasks, monitoring, and lifestyle change as part of the practical burden of illness (9,10). Therefore, low confidence should not be interpreted only as poor motivation or lack of education; it may indicate that the plan has exceeded the patient's available capacity.

The findings also show that shared decision-making must be adapted to the realities of multimorbidity. Participants were not simply choosing between two options for one disease. They were often trying to balance pain, mobility, cardiovascular risk, diabetes control, side effects, frailty, emotional distress, family roles, work demands, and follow-up responsibilities. This complexity makes prioritization essential. Existing shared decision-making models emphasize information exchange, deliberation, and preference-sensitive decisions, but multimorbidity requires these processes to include explicit discussion of trade-offs across conditions (15,16). The present findings are consistent with patient-priorities care, which argues that clinical decisions for older or complex patients should be aligned with what matters most to the patient rather than only with disease-specific targets (13,17). Confidence improved when participants felt supported to understand which goals were urgent, which could be modified, and how competing advice should be negotiated.

Family support was another important but ambivalent influence on confidence. Participants valued family assistance with medicines, transport, appointment attendance, symptom monitoring, reassurance, and explanation of instructions. For some patients, family involvement made complex care more feasible and strengthened confidence in the plan. However, family support could also reduce confidence when relatives became controlling or displaced the patient from decision-making. This finding suggests that family inclusion in multimorbidity care planning should not be treated as automatically beneficial. Instead, clinicians should ask patients how they want family members to be involved, what type of support is useful, and where the boundary lies between assistance and loss of autonomy. In this way, family engagement can strengthen implementation while preserving patient ownership of the plan.

Follow-up reliability appeared to function as a practical marker of care commitment. Participants were more confident when they knew when review would occur, who would contact them, how test results would be communicated, and what they should do if symptoms, side effects, or uncertainty developed before the next appointment. This finding reinforces evidence that personalized care planning is most useful when it involves discussion, goal setting, review, and continuing support rather than merely producing a document (14). It also aligns with multimorbidity intervention evidence suggesting that patient-centred approaches are more relevant when they address care coordination, functional priorities, and ongoing support rather than adding generic disease-management tasks (29). In this study, reliable follow-up transformed a care plan from a static instruction into an active, adjustable process.

Medication burden and fear of side effects were closely connected to confidence because patients with multimorbidity often interpret safety through explanation, monitoring, and review. Polypharmacy may be clinically necessary, but it can also create uncertainty when patients do not know why each medicine is required, whether interactions have been considered, and what symptoms should prompt review. Medication safety guidance emphasizes the importance of reviewing medicine regimens, reducing avoidable harm, and supporting patients to raise concerns about side effects (18,19). The findings suggest that medication review should be framed not only as a pharmacological safety activity but also as a confidence-building process. When patients believe that someone has reviewed the whole regimen across conditions, they are more likely to perceive the plan as coherent and safe.

The study contributes to multimorbidity care by conceptualizing patient confidence as an indicator of care-plan usability. Confidence was shaped by whether care planning reduced complexity or added to it, whether it clarified priorities or left patients to reconcile competing instructions, and whether follow-up demonstrated continuing responsibility. This interpretation extends existing multimorbidity and treatment burden literature by showing that confidence is formed at the intersection of coordination, capacity, continuity, family negotiation, and review reliability. It also suggests that health services should not evaluate care planning only by whether plans are documented, but by whether patients can understand, enact, and trust those plans in everyday life.

The findings have practical implications for clinicians and care systems. Long-term care plans for multimorbidity should identify a named professional or responsible team, include an explanation of how recommendations across conditions fit together, document patient priorities, review medication burden, clarify trade-offs between conflicting advice, specify the role of family members where relevant, and include clear follow-up and safety-net instructions. These actions can help move care planning away from administrative completion and toward patient-centred usability. For patients with lower health literacy, language barriers, limited finances, poor transport access, digital overload, or reduced family support, care-plan confidence may also be an equity issue because the same plan may be more difficult to understand or implement without additional support (20).

This study has limitations that should be considered when interpreting the findings. The sample was small and qualitative, so the findings are intended to provide depth of understanding rather than statistical generalization. Participants represented varied condition combinations and confidence states, but experiences may differ in other health systems, cultural settings, age groups, or service models. Confidence was explored through participant accounts at one point in time, although confidence may change as symptoms fluctuate, medicines are adjusted, family circumstances shift, or follow-up succeeds or fails. The findings also depend on participants' recollection and interpretation of care-planning experiences. Nevertheless, the study offers clinically useful insight into how patients judge long-term care planning and why technically appropriate plans may fail to generate confidence if they are fragmented, burdensome, poorly explained, or insufficiently reviewed.

CONCLUSION

Patient confidence in long-term care planning for multimorbidity depended on more than the presence of a written or verbally communicated plan. Participants were more confident when care plans were understandable, realistic, coordinated, personally relevant, regularly reviewed, and linked to a

recognizable professional or care team responsible for the whole picture. Confidence decreased when advice was fragmented, priorities were unclear, treatment workload exceeded patient capacity, family involvement reduced patient ownership, or follow-up arrangements were unreliable. These findings indicate that multimorbidity care planning should be understood as an ongoing relational and practical process rather than a static administrative document. Care plans are more likely to support patient confidence when they include named coordination, explicit prioritization across conditions, medication and workload review, shared decision-making, respectful family involvement, clear safety-netting, and reliable follow-up. Strengthening these elements may help make complex long-term care more coherent, manageable, and trustworthy for patients living with multiple chronic conditions.

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