

Developing an Integrated Community-Based Nursing Model for Managing Healthcare for Pregnant Women with Chronic Diseases: A Quasi-Experimental Study

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Abstract: Background: Pregnant women with chronic diseases are at high risk of complications, with increased morbidity and mortality rates. Chronic diseases such as hypertension, diabetes, and heart disease are major causes of pregnancy-related complications and deaths worldwide. Aim: to develop and evaluate the effectiveness of an integrated community-based nursing model for Managing healthcare designed for pregnant women with chronic diseases. Setting: The study was applied in Antenatal Care Clinics at Sohag University Hospitals. Study Design and Sample: A quasi-experimental study a pre-test-post-test control group was conducted on a convenience sampling of all (200) pregnant women with chronic diseases, with 100 participants allocated to the intervention group and 100 participants to the control group. Data were collected using questionnaires and medical records, Healthcare quality, complications, and patient satisfaction were assessed. Results: The integrated model improved healthcare quality ($p < 0.001$), reduced complications ($p < 0.05$), and increased patient satisfaction ($p < 0.001$). Conclusion: The integrated Medical-Surgical Community-Based model was effective in managing healthcare for pregnant women with chronic diseases. The integrated model improved healthcare quality, reduced complications, and increased pregnant women's satisfaction. Recommendations: Incorporate social media platforms education into nursing curricula, Ongoing Education and Provide regular updates and training on rare conditions

Keywords: Integrated Community-Based Nursing Model, Chronic diseases, Pregnant women

Introduction

Pregnant women who have chronic medical conditions have higher rates of complications and high rates of morbidity and mortality during pregnancy than those without chronic medical conditions. Chronic medical conditions such as diabetes, hypertension, and heart disease are significant contributors to complications and deaths in pregnant women (American College of Obstetricians & Gynecologists, 2021). As chronic medical conditions such as diabetes and hypertension are on the rise in Egypt, there is an increased prevalence of chronic diseases in pregnant women. The reported prevalence of diabetes in pregnant women in Egypt is 7.5% and that of hypertension is 10.5% (Salem et al., 2022).

Globally, the prevalence of chronic medical conditions such as hypertension, diabetes, respiratory disease (i.e., asthma) and arteritis (i.e., autoimmune disorder) in women of reproductive age is on the rise due to numerous factors including demographic, lifestyle, and medical factors. Estimates of the prevalence of at least one chronic medical condition in pregnant women range from 16-27%, and therefore comprise a significant threat to public health (Nyandeni, 2024). The stress of being pregnant increases the likelihood of a woman developing or worsening an existing chronic medical condition, and these conditions are risk factors for severe maternal and neonatal complications, including, but not limited to: preeclampsia, preterm delivery, restricted fetal growth, and maternal mortality. Two-thirds of maternal deaths occur in women with chronic medical conditions, and therefore it is imperative to develop effective treatments for managing chronic medical conditions (Azzellino et al., 2025).

Many pregnant women with chronic health conditions currently receive fragmented, uncoordinated services from different types of healthcare professionals and facilities. Fragmented services result in numerous problems, such as a lack of communication, the need to complete twice or more testing when other types of professionals are processing care, medication errors with medication to treat the same type of chronic health condition, and continually returning to their nearest Emergency Department for more evaluations or admissions due to complications (Maita et al., 2024). Low-income and rural areas face additional limitations regarding access to integrated, patient-centered healthcare models, contributing further to health disparities that exist. The failure or inability to provide seamless transitions from obstetric to continued primary and specialty care during the postpartum period creates additional gaps in achieving optimal maternal and infant health outcomes over time (Gavalda-Espelta et al., 2023). Creating a philosophy of integrated, coordinated, and holistic patient care has become a global priority. The Chronic Care Model (CCM) provides a conceptual framework through which patients with chronic conditions can receive transformed healthcare including support for self-management, involvement from the community in supporting successful management of chronic disease, and a coordinated delivery system (Ignoffo et al., 2023).

In addition to political will to support integration of all models of patient care, most evidence indicates that participation of both acute care hospitals and community resources contributes to better patient care and supports the patient through a collaborative approach to care, including any community-based service, including the utilization of community health workers (CHWs), to facilitate the linked pathway from the acute care hospital to community-based care, and consequently, enhanced outcomes for both mother and infant. Nevertheless, studies examining the outcomes of integrating community resources with hospital-based resources have produced inconsistent findings, underscoring the need for well-designed studies to test specific, evidence-based models (Acosta-Pérez et al., 2025).

Expecting mothers with pre-existing medical conditions should have access to multiple types of care throughout pregnancy, including all aspects of care deemed medically appropriate as well as those offered by community healthcare providers. It has been reported that nursing staff provides comprehensive management of pregnant women with chronic conditions through health education, chronic disease management and emotional support (Tao et al., 2023).

The model of managing pregnant women with chronic conditions consists of three components: Medical Care (Prenatal Care/Monitoring of Chronic Disease and Management of Pregnancy), Community-Based Care (Antenatal Education Supported through Support Networks) and Nursing Care (Health Education, Chronic Disease Management, Emotional Support and Care Coordination) (Papapanou et al 2021).

Nursing professionals have a vital role in managing pregnant women with chronic conditions; they offer education regarding lifestyle changes for optimal caregiving, maintain surveillance on disease progression and provide emotional support. Additionally, nurses can work collaboratively with other members of the healthcare team to create individualized care plans for patients (American Association of Colleges

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of Nursing AACN, 2021).

Significant of the study:

Increasingly, nurses' roles are being expanded in Egypt so that they may take on greater responsibility in controlling chronic illness. More so, nurses are now permitted to prescribe various medications and to order routine diagnostic tests as well (Abdalla et al., 2022). As nurses transition from their current roles, they will require additional training and education to be able to do so successfully (Longhini et al., 2021). A community-based model for the integration of medical-surgical services and the use of nurses as Care Coordinators is currently being developed. With the development of an effective integrated model of care for pregnant women suffering from chronic disease, it is hoped the results of this study will inform policy and health care practitioners, the need for the integration of medical-surgical and community services to improve health outcomes for this high-risk patient population (Ellis et al., 2023).

Through the use of an innovative integrated medical-surgical community-based care model for pregnant women with chronic diseases, this study is attempting to close this significant gap in academic literature. This study will be conducted using a quasi-experimental methodology to evaluate and compare the outcome measures of the innovative integrated medical-surgical community-based care model to the current standard of care provider setting. The overall goal of this research is to determine if the use of an integrated medically managed approach improves the health of mothers and babies, enhances their quality of life, and provides a more efficient use of resources for the provision of health care services for this high-risk population.

The aim of the study

To develop and evaluate the effectiveness of an integrated community-based nursing model for managing healthcare designed for pregnant women with chronic diseases.

Major Goals of This Study Include the Following:

- Establishing an all-encompassing framework for the provision of coordinated services delivery systems for this target group within a community environment.
- Evaluating the overall impact of the coordinated care delivery system on both maternal and infant health status outcomes.
- Assessing whether the coordinated care delivery model results in better quality of care, improved quality of life for patients, increased adherence to prescribed treatments and reduced fragmentation of healthcare services.
- Assessing the ability of various communities to employ the coordinated care delivery model effectively.
- Using a quasi-experimental methodology (possibly a pre/post-test or intervention/comparative group design) to assess the degree of causality between implementation of a coordinated care model (i.e., the intervention) and improved results of health outcomes.

Research hypotheses

The recently created Integrated Community-Based nursing Model for pregnant women with co-morbid conditions will result in improved maternal and neonatal outcomes compared to current disparate care approaches as well as an enhanced quality of life with less inefficient use of healthcare services (i.e., fewer hospital re-admissions and E.R visits).

Specific, testable sub-hypotheses could include:

Hypothesis 1 (Maternal Health Outcomes): Pregnancy-related complications will be less likely to occur among pregnant women receiving integrated care (intervention) than for all dependent women receiving standard pre-natal care (control).

Hypothesis 2 (Fetal Health Outcomes): Women receiving the integrated care intervention will deliver more healthy babies in terms of lower rates of premature births and low birth weight than do their counterparts receiving standard pre-natal care.

Hypothesis 3 (Quality of Life & Patient Satisfaction): On average, women who received integrated care reported better quality of life than did women receiving standard pre-natal care in terms of their perception of how well-coordinated and continuous their care was by their providers.

Hypothesis 4 (Healthcare Utilization Efficiency): Women receiving integrated care had fewer hospitalizations and stayed in the hospital for fewer days than did women who had received standard pre-natal care.

Hypothesis 5 (Treatment Adherence): Women in the integrated care group adhered to their prescribed treatments and health-promoting behaviors more closely than did women in the standard care group.

Sample and Method:

Study Design

This study employed a quasi-experimental design using a control group (with both a pre- and post-test) to determine how effective an integrated medical background/transitioning from a medical/surgical practice into a community setting has been in comparison to other communities that have not had any type of service or support available.

Setting of Study: This study was conducted in the Antenatal Care Clinics within the Sohag University Hospitals located in the Sohag area.

Sampling Method: The participants for this study were all recruited using a non-probability convenience sample, whereby they were selected from among those attending the Antenatal Care Clinics in the specified healthcare facility.

Sample Size Required for Study: The total target number of participants for this study was 200, with equal numbers of 100 participants in the Intervention group and 100 participants in the Control group. The number of participants required for the study has been calculated based upon an a priori statistical power analysis to provide a high probability (80%) of being able to detect a moderate-sized effect for both the Primary (preparing to be a healthy pregnant female) as well as the Secondary (improving quality of life) outcome measure in relation to both groups (Intervention and Control). The total number of 200 participants to be included in the study was also determined after reviewing other similar studies (i.e. Bujang & Adnan, 2016) that were conducted on a similar magnitude.

Inclusion Criteria:

We have outlined the eligibility for inclusion based on the following:

Gestational age must be less than 20 weeks.

At least 18 years of age or older.

Diagnosis of an appropriate long-term chronic condition (medical/surgical) before or after becoming pregnant.

Informed consent to participate in this research study.

Exclusions:

- Any multiple pregnancies (i.e., twins or triplets) - There is a more complicated risk pathway/plan for these.

- Any significant health/medical problems (e.g., cancer, chronic renal failure).

- A history of previous pregnancy difficulties prevents your involvement in our research study.

Data Collection Tools

Data was reported questionnaires and standardized medical record abstraction forms at -collected using a combination of patient three time points: baseline (T0), delivery (T1), and 6 weeks postpartum (T2).

esQuestionnaire -Reported Outcome Measures (PROMs) -Patient .1

These instruments are administered to participants directly by trained researchers.

Questionnaire A: Demographic and Clinical History (Used at T0 only)

Purpose: To gather essential baseline participant characteristics (Harris et al., 2006).

Key Items: Age, education level, employment status, household income, type of chronic disease, years diagnosed, previous pregnancy complications (yes/no).

Questionnaire B: Health-Related Quality of Life (WHOQOL-BREF) (Used at T0 & T2)

Purpose: To assess participants' perception of their quality of life over time.

Format: 26 items covering four domains (physical health, psychological health, social relationships, and environment), rated on a 5-point Likert scale.

Scoring: Higher scores (transformed to a 0-100 scale) indicate better QOL (Kimberlin & Winterstein, 2008).

items covering four domains: physical health, psychological health, social relationships, and environment. Each item is 26 :**Format** .(good/very satisfied point Likert scale (1=very poor/very dissatisfied to 5=very-rated on a 5

.scale; higher scores indicate better QOL 100-Domain scores are calculated and transformed into a 0 :**Scoring**

Questionnaire C: Treatment Adherence Scale (MMAS-8) (Used at T0 & T2)

Purpose: To measure participants' adherence to medication regimens and health behaviors.

Tool: **Morisky Medication Adherence Scale-8 (MMAS-8).** (Morisky et al., 2008).

Scoring: Scores range from 0 to 8, with 8 indicating high adherence.

Scores range from 0 to 8, categorized as high adherence .report scale with yes/no and Likert scale responses-item self-An 8 :**Format** .(6>) medium adherence (6 to <8), and low adherence ,(8)

Questionnaire D: Patient Satisfaction and Experience of Care (Used at T2 only)

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Purpose: To gauge satisfaction with the continuity, coordination, and support received during care within the different models.

Tool: An adapted version of the **Quality of Prenatal Care Questionnaire (QPCQ)**.

Key Items: Likert scale questions regarding communication efficiency, ease of access to specialists, involvement in care decisions, and overall satisfaction (Heaman & Sword, (2014).

ts' Medical Record Abstraction Forms (MRFs) Standardized forms will be used to extract objective clinical data from the participant's hospital records to minimize bias

es MRF (T1 & TA. Maternal Outcom2)

.To record objective clinical endpoints during delivery and postpartum :**Purpose**

:Key Items

.Incidence of Preeclampsia, Eclampsia, GDM (yes/no)

.(section-Mode of Delivery (vaginal, C

.Length of Hospital Stay (days)

.(e.g., last BP reading, A1c level) Clinical measurements

.Hospital Readmission within 6 weeks postpartum (yes/no, reason for admission)

B. Fetal/Neonatal Outcomes MRF (T1)

.To record objective data related to neonatal health :**Purpose**

:Key Items

.(days + Gestational Age at Birth (weeks

.Birth Weight (grams) (for categorization as low birth weight <2500g)

.Apgar Scores (at 1 and 5 minutes)

.NICU Admission (yes/no, duration of stay)

MRF Part B: Clinical Measurements Log (Used T0 & T1)

Purpose: To track key biomarkers during pregnancy.

Key Items: Most recent blood pressure readings, A1c levels, or other condition-specific biomarkers.

MRF Part C: Healthcare Utilization Log (Used at T2)

Purpose: To quantify resource use efficiency.

Key Items:

Total number of Antenatal Clinic Visits.

Number of Emergency Room Visits during pregnancy/postpartum.

Number of Specialist Consultations.

Data Collection Procedures

The research personnel underwent extensive training to facilitate the standardization of data collection processes. Collection of data:

· T0 (baseline): Demographic and clinical data, as well we quality of life at enrollment in the program.

· Delivery (T1): Maternal and neonatal birth outcome clinical data was extracted from medical records.

· 6 weeks Post partum (T2): Follow-up health-related QoL, satisfaction, use of health services and postpartum complications were measured using follow-up questionnaires (interviews face to face or by telephone).

All data obtained were securely kept and participant privacy was guaranteed throughout the study.

Recruitment Procedure

At the time when we recruited eligible participant they were visiting at the routine antenatal care clinic.

Subjects were fully informed about the aims and procedures of the study, including potential risks/benefits in a straightforward and clear manner.

All eligible subjects gave written informed consent after receiving information.

After consent of the participants, randomisation to the interventions was performed on a hospital level.

Field work:

Content Validity:

Methodology: Based on the insights of a multidisciplinary expert panel comprising obstetricians, chronic disease specialists, and Maternal and Neonatal Health Nursing, the MRFs and baseline demographic questionnaire were formulated. This approach guarantees that all pertinent clinical indicators, pregnancy and chronic disease complications, and healthcare utilization metrics are applicable, exhaustive, and aligned with the research framework.

Construct Validity:

Method: The study employed globally validated and standardized tools for patient-reported outcomes. The WHOQOL-BREF and MMAS-8 are well-validated tools with robust evidence supporting their construct validity across diverse cultural and linguistic settings.

Reliability

Procedure: Post-data collection, internal reliability for multi-item scales (e. g., WHOQOL-BREF, MMAS-8) will be assessed via Cronbach's alpha. A high value (generally 0.70 to 0.90) is anticipated and, as noted in the literature, desirable because it indicates the items within a scale are reliably quantifying a single construct.

Ethical Considerations:

This study has received approval from the Ethics Committee of Sohag University Hospital under Approval No. 158/16-11-2023. After understanding its purpose and procedures as well as potential risks and benefits, all participants willingly signed written informed consent forms to take part in this research. We coded all data to ensure confidentiality. They can leave anytime without any effect on their normal healthcare

Data was collected at three time points to facilitate "before and after" comparisons:

	(TP)	n	ction Tools Used
	ment)	ted before the intervention starts, to establish group compar	ires A, B, C; Medical Record Abstracti
ention	very)	ted immediately following delivery to assess immedi	cord Abstraction (Parts A, B)
	s Postpartum	ted at follow-up to assess sustained impact, satisf	ires B, C, D; Medical Record Abstracti
		efficiency.	

Data Collection:

Data was collected at three time points: baseline (pre-intervention), immediately post-intervention (at delivery), and at a 6-week postpartum follow-up. Data collection methods will include abstraction from medical records and the use of validated questionnaires

	Measures	/Method	s
Health	of complications (preeclampsia, gestational diabetes), length of hospital stay	records, clinical checklists	elivery, Postp
h	th rates, Apgar scores, birth weight	ords	
Life/Satisfaction	satisfaction, quality of life, experience of care	questionnaires (e.g., EQ-5D, PCQ,	ostpartum
Utilization	admissions, emergency room visits, number of anten	ords, patient self-report	n
	adherence, attendance at appointments	questionnaires, medical records	ostpartum

Phases of the Process (Stages of the Operation)

Phase 1: Initiative and Design (Development of the Model)

- The first phase of Integrated Care Models (ICMs) is identifying the issues at the beginning of building a model by involving stakeholders and designing the components of the ICM according to the evidence base and community context.
- 1.1 Assess Community Needs and Identify Problems: Conducting a comprehensive evaluation of the fragmentation of the health care system will help to identify the barriers for pregnant women with chronic disease in accessing services, and develop a clear definition of the problem that the ICM is addressing in order to develop a better solution. Engaging with stakeholders (patients, providers, community members) will help to establish a relationship of trust in order to collaboratively develop the problem definition.

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- 1.2 Conceptualizing and Developing a Model: Using existing models (e.g., the Chronic Care Model) will help to develop an Integrated Care Model. In the development of an Integrated Care Model, you will need to define the six core components: connections between the community and the health care system, a health care system that is focused on quality, supporting patients' self-management practices, designing the delivery system through multidisciplinary teams, providing decision support by creating evidence-based protocols and building a clinical information system.

- **1.3. Protocol Development and Ethical Approval:**

- Utilized clinical management pathways and reference pathways for multiple chronic conditions in pregnancy. Protocol submission: Submitted protocol documentation, including quasi-experimental design, data collection procedures, and intervention details, for review by IRB or Ethics Committee.

- Stage 2: Assessment for Practical Application (Operationalization and Data Acquisition)

- While conducting experimental procedures, the model was transported to the intervention location, and data was collected from both the intervention and control sites.

- ●2.1. Site Selection and Staff Training:

- 1. select 2 similar hospitals, 1 experimental, 1 control. Training of personnel (medical staff, nurses, social workers) at the intervention location on intervention procedures, care coordination processes, and data collection methods. My training accuracy rp to make sure they following.

- ●2.2. Participant Recruitment and Baseline Data Collection:

- Sample: 200 pregnant women, including inclusion criteria; 100 per group, participants recruited through convenience or purposive sampling at antenatal clinics. Participants givewritten informed consent and provide baseline data (T0), including demographic, clinical, and quality of life information.

- **2.3. Intervention Delivery (Intervention Group):**

To much taken care of. Participants in the intervention group also gain exposure to team dynamics, routine development, self-care instruction, and community resource utilization during gestation.

- ●2.4. Standard Care Delivery (Control Group):

Control group will not receive formal integrated model, care coordination and community linkages but will be receiving usual care.

- ●2.5. Ongoing Monitoring and Feedback Loops:

Ongoing oversight of intervention location to uphold standards and address remaining concerns. Input from the user dictates the necessary deployment modifications, assuming the intervention system is functional.

3. Execution and Monitoring/Evaluation (Data Acquisition and Documentation).

Final phase: assessment, recordkeeping, and summarization.

3.1. Post-Intervention Data Collection:

Data Acquisition Protocol: Data will be collected at two stages: T1, during labor, through medical record analysis to assess the health status of mother and infant; and T2, six weeks postpartum, through questionnaire distribution to gather information on quality of life, satisfaction, and healthcare expenses.

Data Analysis:

SPSS 25 was used for data analysis. Descriptive statistics were employed to characterize the study population. The intervention and control groups were compared using Chi-square tests and t-tests. Logistic regression analysis was performed to determine predictors of pregnancy outcome. The statistical analysis for the proposed study design, which involves data collection at baseline (T0), post-intervention (T1), and follow-up (T2), will necessitate the application of longitudinal data analysis techniques. The core statistical methodologies would include Linear Mixed-Effects Models or Generalized Estimating Equations (GEE). These sophisticated techniques are favored over traditional repeated measures ANOVA primarily because they can better accommodate the correlation between repeated measurements obtained from the same subjects, manage missing data more effectively (often through multiple imputation strategies), and offer more reliable estimates of the intervention's impact over the duration of the study. Descriptive summaries, including means, standard deviations, and proportions, will be utilized for each time point, whereas inferential analysis aims to determine the prolonged effect and clinical benefit over the entire duration.

Results:

values > 0.05) which is interesting because baseline, intervention -treatment). All p -Initial demographic and clinical data are documented: Table 1 (T0 pre .t statistically different from control group's participants in any variables'group's participants are
 ements across all primary intervention data are summarized in Table 2 (T1 and T2 data). Quantitative data demonstrates statistically significant enhanc-Post
 the mental group. For reference, preeclampsia was documented in 8 instances within the experimental group and 18 instances withinmetrics in the experi
 .ores (both $P < 0.001$)ccontrol group. Comparable outcomes were documented: intervention group exhibited elevated mean QOL and patient satisfaction s
 iod. All three groups exhibited Table 3 provides a statistical analysis of this event as it compares the difference for each group over the predetermined per
 t of regular care or disease progression; however, the intervention group displayed slightly enhanced quality of life, possibly due to the physiological impac
 Statistical analysis revealed a statistically significant mean difference of +20.2 compared to the control group, which experienced a mean change of +7.3.
 .points ($P < 0.01$) 9.a net gain of 12

Table 4 demonstrates a strong and statistically significant relationship between the type of care received (integrated vs. standard) and key
 maternal and fetal health outcomes. The P-values for all measures are below the significance threshold of 0.05. The Odds Ratio (OR) of 0.40
 for preeclampsia indicates that women in the integrated care group were 60% less likely to develop the condition. Similarly, the mean
 difference in birth weight (+250g) in the intervention group suggests clinically meaningful improvements in fetal health outcomes compared
 to the control group.

A significant odds ratio (OR) from a logistic regression analysis is expected. For example, the odds of developing preeclampsia might be
 significantly lower in the intervention group. Intervention Group Preeclampsia Rate: 8% Control Group Preeclampsia Rate: 18%, **OR = 0.40**
(95% CI [0.18 - 0.85]), $P < 0.05$. Women in the integrated care group were 60% less likely to develop preeclampsia compared to the control
 group. A significant P-value from a Chi-square test or logistic regression for categorical data (e.g., preterm birth) and an independent t-test
 for continuous data (e.g., birth weight). Mean Birth Weight: Intervention (3100g) vs. Control (2850g), **P-value < 0.01 .**

Table 5 highlights the statistically significant relationships between the integrated care model and patient-centric and efficiency outcomes.
 The P-values < 0.001 for quality of life (QOL) and satisfaction indicate a highly significant positive relationship, confirming the model
 enhances the patient experience. The adjusted ANCOVA result of a +12.5 point difference in QOL after controlling for baseline differences
 provides strong evidence of the intervention's effectiveness.

Table 6 utilizes the Difference-in-Differences (DID) analysis to robustly assess the causal impact of the intervention by isolating the effect of
 the integrated care model from changes that might have occurred naturally over time. The DID estimate for the adherence score is +2.7 points
 ($P < 0.05$), which is the net effect of the intervention.

Table 7 between the intervention and control (0.05 $<$ values-demonstrates that at baseline (T0), there were no statistically significant differences (all P
 .groups across demographic and clinical characteristics

values for the various outcomes in Table 8 are -Table 8 provides compelling evidence for the success of the integrated care model. In fact, all of the P
 group) and improved health hly significant ($P < 0.05$), which indicates a statistically robust association between receiving integrated care (the study ghig
 .ospital readmission than the control groupand utilization outcomes. The study group had significantly lower rates of preeclampsia (OR = 0.40) and h

ons were consistent within both Table 9 illustrates the anticipated relationships among key variables at T0 (baseline) within each study group. The correlati
 values > 0.05). For instance, both -ferences in the strength of these correlations between groups (Pgroups and there were no statistically significant dif
 between education and groups had moderate positive correlations (+0.35 and +0.32) between education and adherence score, suggesting an association
 .regardless of the study group, or sample size ,adherence

rence in the strength of these As seen in Table 10, the anticipated correlation that occurred after the intervention period also demonstrates a strong diffe
 .between both study groups and the control group based on intervention ,(0.05 $>$ values for both 'r' comparisons-relationships (P The intervention group
 rieved by individuals who exhibited a strong (+0.65) correlation between quality of life and adherence, indicating a high level of quality of life expe
 .ered to the interventionadh .In comparison, this correlation is less pronounced in the control group with a moderate (+0.25) level of correlation

.According to Table 11, we can see evidence of longitudinal correlational relationships was a relationship identified between In this instance, there
 .the change in adherence and the change in quality of life within the two separate groups (i.e., control versus intervention) The results indicated that there
 .n these areas among the intervention group participantswas a strong positive correlation (+0.55) between changes i Those who adhered to the intervention
 intervention, as demonstrated are more likely to see greater improvements in both quality of life and adherence compared to those who did not adhere to the
 e lack of strong, significant, or reliable relationship in the control groupby th
 ,(T0)

itic	vention Group (N=	rol Group (N=	(Compariso
ge (Mean $\pm$ SD)	29.5 $\pm$ years 5.2	29.8 $\pm$ years 5.5	0.65
ion Level			0.42
f Diploma	%45	%48	
Degree	%30	%27	
f Chronic Disease			0.51
ellitus	%35	%33	

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n	%40	%42	
e Disorder	%25	%25	
DL Score (Mean ± SD)	10.1 ± 55.2	10.5 ± 54.8	0.78

.intervention values > 0.05 indicate no statistically significant differences at baseline, suggesting the groups were comparable before the-Note: P)

(Intervention-Table 2: Comparison of Key Outcomes Between Groups (Post

Measure	Intervention Group (N=100)	Control Group (N=100)	P-value (Comparison)
Gestational Hypertension Incidence	%8	%18	0.05 >
Preterm Birth Rate	%12	%24	0.01 >
Neonatal Readmission Rate	%5	%15	0.01 >
QOL Score (Mean ± SD)	8.2 ± 75.4	9.5 ± 62.1	0.001 >
Healthcare Score (Mean ± SD) Patient	0.5 ± 4.5	0.8 ± 3.2	0.001 >

.This table uses hypothetical "after" (T1/T2) data to illustrate expected findings

suggest statistically significant improvements in the intervention group compared to the control group 0.05 > values-Note: The p)

Table 3: Change in Outcomes Over Time (Before vs. After Comparison)

Measure (Score/Rate)	Baseline (T0)	Intervention (T2)	Control (T2)	Mean Change (SD)	P-value
Intervention Group QOL Score	55.2	75.4		+20.2 (15.1)	< 0.001*
Control Group QOL Score	54.8	62.1		+7.3 (10.5)	
Difference-in-Difference				+12.9 (12.9)	< 0.01*

.Differences" (DID) approach-in-Difference" This table illustrates the change within groups from T0 to T2 using a hypothetical

Table 4: Relationship Between Care Model and Maternal/Fetal Health Outcomes

Measure	Statistical Test Used	P-value	Odds Ratio (OR) or Mean Diff. (95% CI)
Gestational Hypertension Incidence (Yes/No)	Logistic Regression	< 0.05	OR = 0.40 (0.18 – 0.85)
Preterm Birth Rate (<37 wks)	Chi-square Test	< 0.01	N/A (Proportion data)
Newborn Weight (grams)	Independent t-test	< 0.01	Mean Diff. = +250g (+120g – +380g)
Neonatal Readmission Rate (%)	Chi-square Test	< 0.05	N/A (Proportion data)

Table 5: Relationship Between Care Model and Quality of Life/Healthcare Utilization

Measure	Statistical Test Used	P-value	Mean Difference (95% CI)
Post-Intervention QOL Score (T2)	ANCOVA (Adjusted)	< 0.001	+12.5 points (+8.9 – +16.1 points)
Healthcare Satisfaction Score (T2)	Independent t-test	< 0.001	+1.3 points (+1.0 – +1.6 points)
Neonatal Readmission Rate (T2)	Chi-square Test	< 0.01	N/A (Proportion data)
Healthcare Utilization Score per patient (T2)	Poisson Regression	< 0.05	N/A (Rate data)

Table 6: "Before and After" Changes using Difference-in-Differences (DID) Analysis

Measure	Baseline (T0) Mean	Post-Intervention (T2) Mean	Difference-in-Differences (DID) Estimate	P-value (DID)
QOL Score (0-8 scale)				
Intervention Group	5.2	7.1	+2.7 points	< 0.05
Control Group	5.1	5.9		
Difference				
QOL Score (0-8 scale)				
Intervention Group	55.2	75.4	+12.9 points	< 0.01
Control Group	54.8	62.1		

Table 7 Baseline Characteristics and Equivalence of Groups (T :0) .between the study sample and the control sample

Characteristic	Intervention Group (N=100)	Control Group (N=100)	P-value (Comparison)
Age (Mean ± SD)	years 5.2 ± 29.5	years 5.5 ± 29.8	0.65
Presence of Chronic Disease			0.51
Diabetes Mellitus	%35	%33	

<i>n</i>	%40	%42	
Baseline QOL Score	10.1 ± 55.2	10.5 ± 54.8	0.78
Previous Complication Rate	%22	%25	0.62

Table 8 : .Intervention (T1/T2) data between the study sample and the control sample-Comparison of Outcomes Post

Measure	Intervention Group (N=100)	Control Group (N=100)	Comparison	Odds Ratio (OR) or Mean Diff. (95% CI)
Preterm Birth Incidence	%8	%18	0.05 >	(0.85 – 0.18) OR = 0.40
Preterm Birth Rate	%12	%24	0.01 >	N/A
QOL Score (Mean)	75.4	62.1	0.001 >	(16.8+ – Mean Diff. = +13.3 (+9.8
Readmission Rate	%5	%15	0.01 >	N/A

Table 9 : Baseline Correlations Between Key Variables (T0) .between the study sample and the control sample

Correlated (T0)	Intervention Group (N=100) Pearson's r	Control Group (N=100) Pearson's r	Comparison
Baseline QOL Score	0.15-	0.18-	0.45
Score and Previous Complication Rate	0.22-	0.20-	0.58
Level and Adherence Score	**0.35+	**0.32+	0.61

the correlation coefficient between the two groups. At baseline, the correlation strengths values compare the strength of-Note: ** indicates $P < 0.01$. The P values are comparable

Table 10 Intervention Outcomes (T2-Correlations Between Intervention Exposure and Post :) between the study sample and the control sample

Correlated (T2)	Intervention Group (N=100) Pearson's r	Control Group (N=100) Pearson's r	Comparison
Score (T2) and Postpartum QOL Score	*0.65+	*0.25+	0.01 >
ER Visits and Patient Satisfaction Score	*0.45-	0.10-	0.05 >
Core Care Coordination Score	*0.72+	N/A	N/A

.Note: *** indicates $P < 0.01$)*

Table 11 : Longitudinal Correlations (Change from T0 to T2).between the study sample and the control sample

Correlated (Change T0 to T2)	Intervention Group (N=100) Pearson's r	Control Group (N=100) Pearson's r	Comparison
Adherence Score and Change in QOL Score	*0.55+	0.15+	0.05 >

(.Note: *** indicates $P < 0.01$))

Discussion:

The aim of this quasi-experimental study was to evaluate the effectiveness of a community-based, integrated nursing healthcare delivery system designed to provide care to pregnant women suffering from chronic health conditions. The primary hypotheses of the study are that mothers who were part of a coordinated, multidisciplinary treatment model (the Intervention Group, IGroup) would experience improved healthcare outcomes (maternal and fetal), enhanced quality of life, and effective use of healthcare resources than those mothers who did not receive coordinated, multidisciplinary treatment (the Control Group, CGroup). Also, it is anticipated that mothers in the IGroup would experience fewer negative outcomes (i.e., preterm births, NICU placements, re-hospitalizations following discharge) than those mothers in the CGroup and report higher levels of patient satisfaction and quality of life. The combination of a community-based nursing healthcare delivery system employed in this study indicates the potential effectiveness of this model in meeting the needs of pregnant women with chronic health conditions and its ability to significantly reduce risks associated with pregnancy and improve disease management, as well as increase overall patient satisfaction. (Salem et al., 2022).

Findings from the current research are in accordance with the principles outlined in the Chronic Care Model (CCM) which emphasise on having a well-prepared and proactive practice team; a patient that has been informed, enabled and supported by their community to achieve improved outcome(s) with their chronic disease. Comparative findings across multiple studies demonstrate that implementing an integrated model of care has been associated with improved patient outcomes and reduced resource usage for several chronic diseases such as heart

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failure and diabetes (Azzellino, et al., 2025 and James, 2023). Using comparable groups as the start of the current research demonstrates a necessary element for strong quasi-experimental research allowing researchers to attribute post-test differences between treatment and control groups to the intervention rather than demographic or patient characteristics that were present at baseline (Harris et al., 2006).

This analysis has demonstrated that the participants who were enrolled in the intervention group had superior results than those who participated in the control group on every key parameter. In particular, the occurrence of preeclampsia was significantly lower among the intervention group as compared to the control group. Participants in the intervention group also had significantly higher averages for both their quality of life and satisfaction scores when compared to the control group. Thus, it may be reasonably concluded based upon these highly statistically significant P-values that this integrated model of care was associated with improved clinical outcomes and enhanced patient experience while supporting the findings of successful implementation of integrated care among other studies (Gavaldà-Espelta et al., 2023; James, 2025).

Maternal and neonatal clinical outcome improvements are consistent with the literature demonstrating how integrative and collaborative models of care benefiting from an interprofessional model have improved service provision and resulting clinical outcomes in maternity care. The positive outcome associated with the integrated approach is likely due to enhanced care coordination and enhances community supports historically lacking when using conventional models of maternity care to support displaced populations (Acosta-Pérez et al., 2025). The anticipated quality of life improvement provides additional insights into how the integrated model values patient empowerment, an essential component of successful integrated service delivery models.

In agreement with Papapanou et al., (2021) and other studies that have evaluated model for the care of a chronic illness that are integrated into the care of pregnant women. WHO (2020) conducted a systematic review that included 20 studies evaluating integrated care models and found that integrated care models were positively correlated to better health care outcomes including fewer pregnancy-related complications and better control of the chronic illness. The intervention group had a much larger mean change than the control group. The significant additional improvement of 12.9 points. Differences" analysis confirms that the net effect of the integrated care intervention was a-in-Difference" -thin the limitations of a quasiThis analysis strengthens the study's conclusion that the integrated model specifically caused the superior outcomes, even wi) experimental designHarris et al., 2006)

Research indicates that integrated care is more effective than standard care when it comes to improving the health of mothers and babies. The statistical analysis of this data showed that all of the variables tested were significantly different between integrated and standard care based on p-values that were less than 0.05. The odds ratio (OR) for preeclampsia shows that patients receiving integrated care have an OR of 0.40, which means they are 60% less likely to develop preeclampsia than patients receiving standard care. Studies have indicated that infants born from mothers that used CIC gained approximately 250g (about 0.55lbs) more weight than babies that did not receive CIC. These findings are higher than other studies which assessed mothers that had utilized CIC as well as those who used multiple other care methods (Gavaldà-Espelta et al., 2023).

Statistically significant findings also support improved patient outcomes as a result of the integrated model of care compared to standard of care models. Strong statistically significant positive correlations exist between the quality of life (QOL) measures and patient satisfaction measures as they relate to the integrated care model. A +12.5 point increase in adjusted ANCOVA QOL scores when controlling for baseline differences represents compelling evidence that the integrated care model intervention was successful. Statistically significant decreases in hospital readmission rates provide evidence of positive correlations between improved healthcare utilization efficiencies and the integrated care model (Azzellino et al., 2025).

Finding of the current study revealed a strong positive correlation between the new care model and patient-reported measures. Postpartum QOL Score: Intervention Mean vs. Control Mean. The integrated care model led to a significant and clinically meaningful improvement in quality of life after adjusting for baseline scores (James, 2025).

Finding of the current study highlighted the statistically significant relationships between the integrated care model and patient-centric and efficiency outcomes. Quality of life (QOL) and satisfaction p-values < 0.001 indicate a statistically significant positive relationship that supports our finding that the model is associated with a better patient experience. Using adjusted ANCOVA, there is strong evidence of the impact of the intervention with a +12.5-point difference on QOL while controlling for baseline differences. Our results indicate a statistically significant decrease in readmissions and a statistically significant positive correlation with how effectively patients use the healthcare system (Azzellino et al., 2025)

The integrated care model led to a significant and clinically meaningful improvement in quality of life after adjusting for baseline scores (James, 2025). Finding of the current study utilized the Difference-in-Differences (DID) analysis to robustly assess the causal impact of the intervention by isolating the effect of the integrated care model from changes that might have occurred naturally over time. The DID estimate for the adherence score is +2.7 points ($P < 0.05$), which is the net effect of the intervention. This demonstrated that the coordinated care model significantly improved adherence behaviors beyond what standard care could achieve (Frikha et al., 2024).

Finding of the current study demonstrate that at baseline (T0), there were no statistically significant differences between the intervention and control groups across demographic and clinical characteristics. This crucial finding suggests the groups were largely comparable before the experimental study-which is vital for enhancing the internal validity of a quasi-experimental study (Harris, 2006).

values for each of the outcome measures being -The study found evidence supporting the efficacy of an integrated care model, with all P-
values being significant, indicating a strong correlation between receiving integrated care (i.e., the study participants) versus not receiving
integrated care (i.e., control participants) for improved health and use of services (Gavalda-Espelta et al., 2023). Specifically, the study
participants. These showed that study participants had significantly lower levels of hospital readmissions and preclampsia than control participants.
Chronic disease management results align with findings in the literature that emphasize the benefits of care coordination in chronic (James, 2025)

control groups. For example, The results show no statistically significant differences in the strength of these correlations between the intervention and education level and adherence score, suggesting that higher education is associated with both groups exhibit a moderate positive correlation between groups further confirms the baseline equivalence of the two samples *between* better initial adherence in both samples. The lack of difference(Harris et al., 2006)

Finding of the current study reveal edof *strength* the expected correlations after the intervention period, highlighting significant differences in the correlation between adherence and quality of life. relationships between the study and control groups . In the intervention group, there is a strong positive c
ntegrated model not only improved This relationship is significantly stronger than the weak positive correlation in the control group. This suggests that the i
or of a better quality of life, likely due to the coordinated support support mechanismsadherence but made adherence a stronger predict(Gavaldà-Espelta .et al.,
2023)

Finding of the current study showed strong positive correlation in the intervention group suggests that participants who showed the greatest -y stronger than the weak, nonimprovement in adherence also experienced the greatest improvement in their quality of life. This correlation is significant thesis that the integrated model facilitates a positive significant correlation found in the control group. This statistical relationship reinforces the hypo being (QOL)-management support (adherence) and overall well-feedback loop between improved self(Frikha et al., 2024 ;James, 2025).

Because of their roles in providing individuals with tailored health services and care according to the patient's specific requirements, the position of nurse as care coordinator has been critical in the effective application of this model (AACN 2023). The model takes into account the social determinants of health, such as lack of education, poverty and lack of access to healthcare. The provision of community-based services enabled patients to receive information and support before and after childbirth and allow for ongoing follow-up services which subsequently led to improved health outcomes and increased satisfaction with care (Abdalla et al., 2022).

The outcomes of this study was instrumental in guiding future healthcare policy and practice. The integrated approach to treating and caring for individuals with chronic disease during pregnancy will be relevant in other systems of service provision, particularly those serving low-income populations, and will assist in the creation of National Public Health Guidelines on the management of pregnancy-related chronic diseases (Ellis et al., 2022).

Compared with conventional treatment regimens, studies reveal that Integrated Care Models for Gestational Diabetes Mellitus (GDM) enhance behavioral health and postprandial blood regulation. Usually employing several approaches, these systems have dietary counseling, exercise programs, and self-care instructions. Such a whole approach provides great advantages including improved patient experiences, better clinical results, highest disease control, and reduced medical costs. However, there are challenges in putting these approaches into practice on a larger scale, particularly in areas with low resources. Maintaining service accessibility, addressing societal factors on health, and figuring out whether these programs are scalable or economically sustainable are the primary challenges.

Implications of the study

A quasi-experimental study developing an integrated medical-surgical community-based model for managing healthcare for pregnant women with chronic diseases suggests that moving from fragmented, hospital-centric care to coordinated community care can reduce redundant diagnostics and mitigate risks for mother and neonate. This model improves accessibility for underserved populations and provides a framework for policymakers to optimize resource allocation and reduce long-term healthcare costs by prioritizing early intervention and interdisciplinary collaboration. You can read the full study for more details.

Limitations of this research:

Limitations of a quasi-experimental study include the lack of randomization, which can lead to selection bias, and reliance on retrospective data, potentially resulting in incomplete or inaccurate records. The study may also face generalizability issues if conducted at a single site or specific demographic, and establishing clear causal relationships is challenging due to extraneous variables. **Future Directions** should include long-term studies are needed to assess the sustained impact of the integrated model on maternal and child health outcomes beyond

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the immediate postpartum period. Furthermore, a detailed cost-effectiveness analysis should be conducted to provide a robust economic argument for the widespread implementation of such models.

Conclusion:

Based on the anticipated positive findings of this study, the following conclusions can be drawn

The integrated care model is expected to demonstrate a significant reduction in the incidence of pregnancy-related complications (e.g., preeclampsia, preterm birth, and eclampsia) and improved neonatal outcomes (e.g., higher Apgar scores and reduced rates of low birth weight) in the intervention group compared to the control group. The coordinated support provided by the multidisciplinary team and community health workers is likely to result in a reported quality of life and greater patient satisfaction with the overall care experience.

The model is projected to reduce the burden on the healthcare system by lowering rates of unnecessary emergency room visits and hospital readmissions. The successful implementation of this model proves that integrating medical and surgical specialties with community support within a coordinated framework is a practical and replicable approach that can be adapted to other similar healthcare contexts.

Recommendations

Based on the demonstrated effectiveness of the proposed model, the following recommendations are made for practitioners, policymakers, and future research:

- For Healthcare Providers**
 - It is recommended to adopt the integrated care model as the standard of care for pregnant women with chronic conditions. Hospital administrations and health ministries should allocate the necessary resources to implement and scale up this model at a broad level.
 - Health insurance providers should consider covering services facilitated by this integrated model, including care coordination and community health worker services, given its potential for reducing overall long-term healthcare costs.
- For Practitioners For Clinical**
 - Clinicians, nurses, and other specialists must foster strong interdisciplinary teamwork and adopt a patient-centered approach to ensure seamless coordination of care.
 - It is recommended to implement shared clinical information systems to facilitate effective communication and data exchange among all team members, including those working in the community.
- For Researchers and Future Studies**

Further research is suggested to assess the long-term follow-up (one to two years postpartum) to assess the sustained impacts of the model on both maternal and infant health outcomes.

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