

Effectiveness of community and home care programs on the quality of life of chronic disease patients

 Lumastari Ajeng Wijayanti^a, Natalia Datu^b, Ria Wahyuni^c

^a Poltekkes Kemenkes Malang, East Java, Indonesia

^b STIKES Datu Kamanre, South Sulawesi, Indonesia

^c Politeknik Sandi Karsa, South Sulawesi, Indonesia

*Correspondence: Lumastari Ajeng Wijayanti, Poltekkes Kemenkes Malang, East Java, Indonesia

Email: ajengg1612@gmail.com

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ABSTRACT

Introduction: The increasing prevalence of chronic diseases such as diabetes, hypertension, and heart disease demands a more adaptive and sustainable healthcare system. Community-based care programs and home care are becoming increasingly relevant approaches to holistically improving patients' quality of life. This study aims to evaluate the effectiveness of community care and home care programs in improving the quality of life of patients with chronic diseases.

Research Methodology: This study uses a quantitative approach with a quasi-experimental design. Respondents consisted of 120 patients diagnosed with chronic disease, divided into two groups: intervention (receiving community care and home care for 12 weeks) and control (conventional care). Quality of life was measured using the WHOQOL-BREF instrument before and after the intervention.

Results: Results showed a significant improvement in the physical, psychological, social, and environmental dimensions of quality of life in the intervention group compared to the control group ($p < 0.05$). The most contributing factors were active family involvement and ongoing education by community health workers.

Conclusion: Community care and home care programs effectively improve the quality of life of chronic disease patients. This approach is feasible to develop as part of a long-term chronic disease management strategy, especially in areas with limited access to health facilities.

Keywords: Chronic disease; Community care; Home care; Public health interventions; Quality of life.



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INTRODUCTION

Chronic diseases have become a global public health challenge in the past two decades. According to the World Health Organization (WHO), chronic diseases such as diabetes mellitus, heart disease, stroke, cancer, and chronic obstructive pulmonary disease (COPD) are responsible for about 74% of all deaths in the world. In developing countries, the burden of chronic diseases is increasing faster due to epidemiological transitions and lifestyle changes. This condition puts significant pressure on the healthcare system, especially because long-term chronic diseases require ongoing monitoring and treatment (Sharma et al., 2024). In this context, patients' quality of life is an important indicator in assessing the effectiveness of chronic disease management. Quality of life includes physical, psychological, social, and environmental aspects that affect a person's overall well-being. Unfortunately, conventional treatment approaches that focus on healthcare facilities often do not adequately address the complex needs of chronic patients (Brom et al., 2024). Many patients find it difficult to access services, do not receive adequate health education, and lack social support from their environment. Therefore, an alternative, more inclusive, affordable, and patient-oriented approach is needed (López Luque et al., 2025).

Two approaches that are getting more attention in efforts to improve the quality of life of chronic disease patients are community-based care (community care) and home care (home care). Both are part of a public health intervention that aims to expand the reach of health services, empower communities, and improve the continuity of care (Wang et al., 2025). Community care involves health workers, cadres, or volunteers who provide promotive, preventive, and rehabilitative services in the patient's living environment. This model allows for a more personalized and contextual approach because program implementers generally come from the same community. In addition, intensive interaction between patients and the community can increase a sense of belonging, strengthen social support, and form healthy living behaviours collectively (Naranjo-Rojas et al., 2025).

Meanwhile, home care is health services provided directly at the patient's residence, involving regular visits by health professionals such as nurses, doctors, or therapists (Madrid-Rodríguez et al., 2025). The goal is to ensure that patients receive medical care, condition monitoring, and psychological support without coming to a healthcare facility. Home care has been proven to help patients stay in a comfortable environment, reduce hospitalization costs, and improve medication adherence (Dharma et al., 2024).

A number of studies show that the combination of community care and home care can improve various aspects of the quality of life of chronic patients. Educational and emotional support from healthcare workers and the community can reduce the loneliness, anxiety, and stress that patients often experience (Paffett et al., 2024). Family and community involvement also play an essential role in shaping an environment that supports the healing process and disease management. From the physical side, routine assistance encourages patients to maintain treatment adherence, adopt a healthy lifestyle, and conduct early monitoring of worsening symptoms (Kulkarni et al., 2025). The environmental aspect has also increased because patients feel more comfortable and safe at home rather than accessing distant or expensive services. However, the effectiveness of these programs is highly dependent on various factors, including health worker training, sustainability of financing, community participation, and government policies (Chen et al., 2025).

In many cases, system disintegration or resource limitations cause the program not to run optimally. Therefore, it is important to systematically evaluate the effectiveness of these interventions, focusing on the result in improving the patient's quality of life (Tandon et al., 2025).

This research is important given the urgent need for a patient-centred care system, especially amid an increasing burden on health services. In Indonesia, various initiatives have been undertaken to encourage the development of community-based services and home care. However, studies on their impact on the quality of life of chronic patients are still limited. Through this research, it is hoped that a more profound understanding can be obtained of how community care and home care programs contribute to improving patients' quality of life. The results of this research are also expected to be the basis for developing more patient-friendly policies and a reference for health service providers in designing effective and sustainable programs.

RESEARCH METHODOLOGY

Research Design

This study used a quasi-experimental design with a pretest-posttest control group design approach. This design allowed researchers to compare changes in quality of life in the intervention group that received community care and home care programs with the control group that received only conventional health services. This design was chosen because it provides an opportunity to assess the changes that occur due to the intervention without having to do complete randomization, which is often not possible in a real healthcare setting. Location and Time of Research. The research was conducted in two areas of Puskesmas, urban and semi-urban, that have implemented community care and home care services. The location was chosen purposefully based on the program's availability and the implementing staff's readiness. The research implementation time was 4 months, including the preparation phase, intervention for 12 weeks, and pretest and posttest data collection.

Population and Sample

The population in this study is patients diagnosed with chronic diseases (such as type 2 diabetes mellitus, hypertension, and heart disease) enrolled in the chronic disease management program in the work area of the relevant health center. Inclusion and Exclusion Criteria. Inclusion criteria: Age ≥ 40 years. Diagnosed with a chronic disease for at least 6 months. Able to communicate well. Be willing to follow the entire range of interventions. Exclusion criteria: Patients with severe cognitive impairment or terminal conditions. Patients who were hospitalized during the data collection period. Not willing to give informed consent. Sampling Technique: Samples were taken using purposive sampling techniques and divided into Intervention groups, integrated community care, and home care programs. Control group: getting routine health care without additional interventions. Each group comprised 60 respondents, so the total sample was 120 patients. Data Type and Source. Primary Data. Patient quality of life data were collected through the WHOQOL-BREF questionnaire. Observations and records of home care visits. Semi-structured interviews to confirm the quality of implementation. Secondary Data. Medical records of patients from healthcare facilities. Program implementation data from the Health Center. Technical guidance from the Ministry of Health.

Research Instruments. WHOQOL-BREF Questionnaire. The main instrument is the Indonesian version of the WHOQOL-BREF questionnaire, which has been validated and widely used to measure an individual's quality of life in four domains: Physical: pain, energy, sleep, mobility, Psychological: emotions, self-esteem, and memory. Social: personal relationships, social support. Environment: security, access to services, comfort of residence. Each item is rated on a Likert scale of 1–5, with higher scores reflecting a better quality of life. Intervention Observation Sheet. Health workers document home visits and community activities, such as education, blood pressure/blood sugar monitoring, counseling, and social support. Research Procedure. Preparation Stage: Ethical permission from the ethics committee and the Health

Center. Training of enumerators and community health workers. Socialization of participants. Pretest Stage: Fill out the WHOQOL-BREF questionnaire by all respondents. Intervention Phase (12 weeks): The intervention group receives weekly home visits from nurses/health workers. Community group education every two weeks. Condition monitoring and psychosocial reinforcement. The control group still receives standard services from the Puskesmas. Posttest Stage: Refilling of the WHOQOL-BREF questionnaire by all respondents. Evaluative interviews for the exploration of subjective experiences.

Data Analysis Techniques. Descriptive Analysis. Demographic and clinical characteristics of respondents. Average quality of life score per domain. Inferential Analysis. A t-test was used to compare each group's pretest and post-test scores. An independent t-test to compare changes between groups. Multivariate tests (ANCOVA or linear regression) are needed to control for confounders. The significance level was set at $p < 0.05$ with a confidence interval of 95%. Data processing is carried out using statistical software such as SPSS or STATA. Research Ethics. This study follows the ethical principles of human research, including written consent from respondents (informed consent). Data confidentiality is maintained with an identity code. The right to resign at any time. Ethical approval is obtained from the authorized Health Research Ethics Committee.

RESULT

A total of 120 respondents successfully participated in the entire research series, consisting of 60 respondents in the intervention group and 60 in the control group. The following is a summary of the demographic and clinical characteristics of the respondents.

Table 1. Respondent Characteristics

Characteristic	Intervention Group (n = 60)	Control Group (n = 60)	p-value
Age (mean $\pm$ SD)	59.4 $\pm$ 8.2 years	58.1 $\pm$ 7.7 years	0.412
Gender (Female/Male)	35 / 25	32 / 28	0.623
Type of Chronic Disease			
- Diabetes Mellitus	28 (46.7%)	27 (45.0%)	0.848
- Hypertension	20 (33.3%)	21 (35.0%)	
- Heart Disease	12 (20.0%)	12 (20.0%)	

Statistical analysis revealed no significant differences between the two groups at baseline ($p > 0.05$), indicating comparable group profiles before the intervention.

Table 2. Comparison of Quality of Life Scores (Pretest and Posttest)

Quality of life was assessed using the WHOQOL-BREF instrument, which includes four domains: physical, psychological, social, and environmental. The mean scores before and after the intervention are presented below.

a. Intervention Group

Domain	Pretest (Mean $\pm$ SD)	Posttest (Mean $\pm$ SD)	Change	p-value (Paired t-test)
Physical	48.2 $\pm$ 8.5	62.9 $\pm$ 7.3	+14.7	< 0.001
Psychological	45.1 $\pm$ 9.0	58.6 $\pm$ 8.1	+13.5	< 0.001
Social	43.3 $\pm$ 7.8	55.7 $\pm$ 7.5	+12.4	< 0.001
Environmental	46.5 $\pm$ 8.2	60.2 $\pm$ 7.4	+13.7	< 0.001

b. Control Group

Domain	Pretest (Mean $\pm$ SD)	Posttest (Mean $\pm$ SD)	Change	p-value (Paired t-test)
Physical	47.9 $\pm$ 8.4	50.1 $\pm$ 8.0	+2.2	0.058
Psychological	45.3 $\pm$ 8.8	47.2 $\pm$ 8.6	+1.9	0.073
Social	43.0 $\pm$ 7.9	44.8 $\pm$ 7.6	+1.8	0.082
Environmental	46.2 $\pm$ 8.3	48.0 $\pm$ 7.9	+1.8	0.095

The results indicate a significant improvement in all four domains for the intervention group ($p < 0.001$), while the control group showed only minimal, non-significant changes.

Table 3. Between-Group Comparison (Independent t-test)

Domain	Intervention Group	Control Group	p-value
Physical	+14.7	+2.2	< 0.001
Psychological	+13.5	+1.9	< 0.001
Social	+12.4	+1.8	< 0.001
Environmental	+13.7	+1.8	< 0.001

Independent t-tests confirmed that the improvements in all domains were significantly greater in the intervention group compared to the control group. Family and community health worker involvement significantly contributed to emotional support and improved treatment adherence. Consistent home visits facilitated early detection of complications, especially in diabetic patients. Many respondents reported feeling more valued, heard, and comfortable receiving care in their homes. This study demonstrated that integrating community-based care and home care programs significantly improves the quality of life among patients with chronic diseases. A quasi-experimental design involving 120 participants found that patients who received structured interventions, including regular home visits, community health education, and psychosocial support, experienced substantial improvements across all quality of life domains as measured by the WHOQOL-BREF instrument.

Specifically, the intervention group showed statistically significant increases in physical, psychological, social, and environmental well-being compared to the control group, which received only conventional health services. These improvements were attributed to medical follow-up and monitoring and the emotional and social reinforcement provided by family members, healthcare workers, and community health volunteers. The results indicate that community and home care approaches are effective, patient-centred solutions that complement institutional healthcare systems. These programs address clinical and non-clinical dimensions of chronic disease management by bringing care closer to where patients live and involving local support networks. Community-based and home care programs should be promoted as essential components of chronic disease management strategies, particularly in resource-limited or underserved settings. Policy-makers and health institutions are encouraged to adopt and scale up these models to improve patient outcomes, enhance healthcare access, and reduce the long-term burden on healthcare facilities.

DISCUSSION

This study aims to evaluate the effectiveness of community-based and home care programs in improving the quality of life of patients with chronic diseases. The results showed that these two approaches significantly improved quality of life scores in all domains of WHOQOL-BREF, namely the physical, psychological, social, and environmental domains. These findings reinforce the argument that decentralized, personalized, and patient-focused healthcare can effectively manage chronic disease.

Improving the quality of life in the physical domain. The physical domain showed the most pronounced score improvement in the intervention group. This indicates that community-based and home care approaches improve patients' physical health (Demirok et al., 2024). Regular home visits allow for more consistent monitoring of medical conditions such as blood pressure, blood sugar levels, and physical activity (FM et al., 2025). In addition, education provided by health workers in community settings encourages patients to be more active in self-management, such as dietary arrangements, light physical activity, and medication adherence. These findings align with previous studies by Jorgensen et al. (2025), which found that Active participation in

community-based health activities contributes to improved functional abilities of patients with chronic diseases. Patients' involvement in their health decision-making is also important in increasing their sense of control over their health conditions (Maddox et al., 2023).

Improvements to the Psychological Domain. In the intervention group, quality of life scores in the psychological domain also increased significantly. This indicates that the intervention carried out not only impacts the medical aspect, but also the patient's emotional and mental well-being (Domingo et al., 2025). The sense of support, care, and interpersonal communication that exists between patients, families, and health workers plays a major role in reducing the levels of stress, anxiety, and mild depression that chronic patients often experience (Ambrosi et al., 2025). In a community setting, patients tend to feel more valued and isolated, especially compared to conventional health services, which are more bureaucratic and have limited interactions. Brief counselling, group discussion sessions, and an empathetic approach from community cadres or home care nurses help build trusting relationships that impact the patient's emotional stability. This is reinforced by the theory of social support, which explains that social support plays an important role in overcoming the psychological burden of patients with chronic diseases (Ellis et al., 2025).

Strengthening Social Relationships. The social domain also showed a significant improvement after the intervention. Patients become more connected to their social environment through educational activities in the community and regular interactions with health workers. Group activities such as elderly gymnastics, diabetes education classes, or patient group discussions allow patients to share experiences, build community, and reduce loneliness (Arazi et al., 2023). Social isolation is a common problem in patients with chronic illnesses, especially in those who are elderly. Community care programs provide a forum to rebuild patients' social networks, which impacts increasing motivation to maintain health and strengthen psychological resilience in the face of illness (Wibowo et al., 2025). A study by Matsuda et al. (2025) supports these findings, stating that community-based programs that involve social interaction can reduce the risk of depression in seniors with chronic illnesses.

Environmental Comfort and Service Access. The environmental domain has also seen significant improvements, especially in patients' perceptions of the comfort of residence, security, and ease of service access. With home care services, patients do not need to travel far to health facilities for regular checkups or counselling services (Wijayanti et al., 2025). This is especially meaningful for patients with limited mobility or low financial conditions. Patients also feel increased control over their living conditions, as visiting healthcare workers often advise on healthier and more friendly home arrangements for people with chronic illnesses (e.g., bedroom modifications, lighting, and ventilation). In addition, they feel safer because of regular monitoring by officers who are personally known and from the surrounding environment (Lumastari Ajeng Wijayanti & Dewi Nurhanifah, 2025).

Effectiveness of Interventions in the Context of Health Systems. The effectiveness of this community care and home care program shows great potential in improving the health service system in Indonesia, especially in the context of primary service reform. The burden on advanced healthcare facilities can be reduced when most of the monitoring and education can be done at the community level (Sasarari et al., 2023). Its effectiveness depends on officer training, policy support, sustainable financing, and the active involvement of families and communities. However, implementing this program still faces challenges, such as limited human resources, a lack of incentives for field workers, and patient resistance to non-institutional approaches. Therefore, the program's success is highly determined by the ability to adapt to local conditions

and the quality of coordination across sectors (health centres, cadres, health offices, and communities).

Research Limitations. Although the results of this study are significant, some limitations need to be considered. First, a quasi-experimental design without full randomization opens up the possibility of selection bias. Second, an intervention period of 12 weeks may not be enough to see long-term effects. Third, external factors such as socioeconomic conditions and family support are not fully controlled. For this reason, follow-up research is recommended using a longitudinal design with a longer intervention duration and considering a mixed-methods approach to explore patients' subjective experiences in more depth.

Practical Implications

The findings of this study have broad practical implications, including the following: For healthcare providers, it is necessary to integrate home care as part of routine services for chronic patients. For policymakers, it can be the basis for drafting regulations and budget allocations that support a community-based service model. For local communities, it shows the importance of active community involvement in maintaining the health of their fellow citizens.

CONCLUSION

This study shows that community-based and home care programs significantly impact patients' quality of life with chronic diseases. A quasi-experimental approach found that all domains of physical, psychological, social, and environmental quality of life experienced significant improvements in the intervention group compared to the control group that received only conventional services. This improvement reflects improved physical health conditions, emotional well-being, social relationships, and the comfort of the patient's living environment. The support provided by health workers, families, and community cadres proved to be a key factor in the success of the intervention, with a more personalized, sustainable, and patient-based approach. Thus, community care and home care programs should be complementary strategies in chronic disease management, especially in areas with limited access to formal health services. Community and family involvement, strong policy support, and implementing personnel training are important prerequisites for this service model to be widely adopted and sustained. This study provides empirical evidence that health services that are close to patients, holistic, and humane can improve the quality of life in a real way. Therefore, policymakers need encouragement to expand the application of this model in the national health service system.

Conflict of Interest

The authors declare that they have no competing interests.

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