MODIFIED OUT ON PASS GUIDELINES FOR THE RE-INTEGRATION OF LONG-TERM RESIDENTS INTO THE COMMUNITY IN QATAR

Anthony Vibar
Author
University of Perpetual
System Laguna
PHILIPPINES
c19-3010-308@uphsl.edu.ph

Karen Lee Tamayo
Co-Author
University of Perpetual Help
System Laguna
PHILIPPINES
karentamayo@gmail.com

Susana C. Bautista
Co-Author
University of Perpetual Help
System Laguna
PHILIPPINES
sbautista28@yahoo.com

ABSTRACT

Within the realm of healthcare, the underutilization of temporary leave provided to patients by healthcare facilities remains a concern. The sole purpose of this study was to modify the out on pass guidelines based on the existing hospital policy to improve the patient participation in community integration programs. Descriptive developmental method, employing medical experts that worked in the hospital of Qatar for five (5) years or more that have knowledge about out on pass program. All medical professionals had submitted voluntarily in the study and used self-made questionnaires for collecting the needed primary data. Twelve medical experts generally “agreed” with the current status of the out on pass program and factors or reasons and their comments on the modified Out on Pass Policy with an average weighted mean of 3. 30, 3. 36 and 3. 37, respectively. The modified policy provides significant improvement of patient participation in the out on pass program. Respondents’ level of acceptance of the modified out on pass policy was “high” with weighted mean of 3. 35. It was concluded that the program effectively provides clear eligibility criteria, specifies pass durations, and outlines relevant conditions or restrictions. These adjustments reflect a holistic approach aimed at enhancing the effectiveness and responsiveness of the policy to the dynamic healthcare. The modified out on pass policy increases patient awareness through proper education and information dissemination which provide continuous communication and follow-up with the families.

Keywords: Current Out on Pass Policy. Modified Out on Pass Policy, Community Integration

INTRODUCTION

Within the world of healthcare, the underutilization of temporary leave granted to patients by healthcare facilities remains a concern. As discussed by Ziltener (2021), the "out-on-pass privilege" is a crucial aspect of patient care, enabling patients to engage in community activities. This intervention has a long-standing global tradition in health practices. A study by Kao (2020) found that "out on pass" interventions were associated with improved quality of life and reduced hospitalization rates among patients with severe mental illness. Mavroudis (2021) identified "out on pass" as a key component of a successful transition program for patients with psychiatric disorders. Furthermore, Song (2020) and Yeon (2021) highlight the importance of community integration and social support in mental health recovery, and emphasizing the significance of "out on pass" in psychiatric practices worldwide. The proposal to modify the current out-on-pass policy has been made due to various factors, including changes in societal norms and expectations, and evolving healthcare practices. These factors necessitate adjustments to ensure that the policy aligns with contemporary standards, and that it remains relevant and effective in meeting the needs of patients and their

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families. Hinson (2019) emphasized that the quality of services in healthcare facilities is closely related to factors such as patient satisfaction and the likelihood of seeking services again. Upadhyai (2019) agrees and suggests that the medical aspects of health service quality include three sub-dimensions: techniques, outcomes, and interpersonal factors. Similarly, Donabedian (2019) argues that healthcare quality can be assessed based on three dimensions: structure, process, and outcome. The technical dimension involves the proficiency, skills, and assessment of healthcare providers, as well as the availability of medical facilities. Kumah (2020) proposes that the current health policy should empower patients in healthcare. Furthermore, emerging insights from patient feedback and changing community dynamics play a crucial role in proposing modifications to the policy. It is crucial to support this proposal to modify the out-on-pass policy to ensure that the healthcare system meets the needs of patients and their families.

After examining the existing out-on-pass policy, it has become clear that there are operational inefficiencies and logistical challenges that need to be addressed. According to the study conducted by Singh and Prasher (2019), potential barriers to effective implementation of the policy include delays, confusion in the application process, and unclear guidelines. Other researchers, such as Smith Park (2020) and Johnson (2018), have also highlighted similar concerns. To make the out-on-pass privilege more accessible and user-friendly for both patients and healthcare staff, proposed modifications aim to streamline procedures and address these operational shortcomings. Additionally, insights from psychological and social perspectives, as suggested by Brown (2023) and Kim (2022), have contributed to the proposal for policy modification. The importance of feedback and expert evaluation in shaping and refining the out-on-pass policy cannot be overstated. According to Maxwell (2020), feedback is a crucial tool for aligning healthcare services with patient needs, promoting efficient utilization of services, and potentially reducing hospital stays. Powell (2020) has also emphasized the role of feedback as a form of public accountability for healthcare services, highlighting its impact on overall service quality. Davis (2018) stress the importance of feedback in improving patient-provider communication and overall healthcare outcomes. Hysong (2018) suggests that feedback can be used to identify areas of improvement in healthcare processes and systems, leading to enhanced patient care. Boulding (2017) suggests that feedback can be used to improve patient satisfaction, trust, and loyalty towards healthcare providers and institutions.

However, Weich (2020) identified a potential disconnect between patients' intentions and providers' focus on complaints, suggesting that overlooking positive feedback and sidelining two-way conversations can hinder the comprehensive improvement of healthcare policies. Incorporating expert evaluation into the out-on-pass policy is equally essential. Experts bring a specialized perspective that goes beyond patient experiences, considering operational efficiency, safety protocols, and broader healthcare goals. Their evaluation adds a layer of scrutiny that ensures the policy is not only patient-centric but also aligned with the overarching healthcare objectives. Meanwhile, Chiu (2018) suggests that expert evaluation can be used to identify gaps and challenges in healthcare policies, leading to more effective and patient-centered care. By integrating both patient feedback and expert evaluation, the out-on-pass policy can achieve a balanced and comprehensive approach to improvement, enhancing its effectiveness and relevance within the healthcare facility. In a study by Greaves (2019), feedback from patients was found to be particularly useful in identifying areas of improvement in primary care services, such as access to care and communication with providers. Despite these numerous studies that investigated about the decreasing number of patients and families taking out on pass privilege and helps to improve the participation of

these residents in community integration programs as no study yet has been conducted particularly in Qatar which talks about out on pass program implemented in the facility. Therefore, this study will modify the out on pass guidelines based on the existing hospital policy which aims to increase the temporary leave request of patients and families leading to participation in the community integration.

Objective of the Study

The overall objective of this study was to develop a modification on the out on pass policy to improve the patient participation in community integration programs. Specifically, this sought to answers to the following sub-problems: (1) What was the current status of the out on pass program implemented in the facility? (2) What were the different factors or reasons leading to propose to modify the current out on pass policy? (3) What modification can be made for the out of pass program? (4) What were the levels of acceptance of different experts who validated the set of questionnaire before its implementation? (5) What were the comments/opinions made by the respondents after reviewing the modified out on pass policy?

LITERATURE REVIEW

Out On Pass

According to Al Falahi (2018) Out on Pass (OOP) is a temporary absence from the hospital without being officially discharged and with intent to return back for further treatment. This does not include the authorized short absence from the unit/ward for a walk around hospital grounds. MoH (2022) represents the main reference for out on pass policies and procedures in MoH. All hospitals' local policies and guidelines have to be modified to conform to the policies and procedures stated in this document. Out on Pass (OOP) requests are strictly regulated and should only be granted in exceptional circumstances, such as a death in the family or extended hospital stays. The treating doctor is the sole authority to grant OOP, but if the patient is under multiple specialties, consultation with other treating doctors is necessary. OOP is not permitted for legally unqualified patients without proper consent, those posing risks to themselves or the public, individuals with impaired consciousness, or those under police custody. Treating doctors can reject OOP requests for significant reasons. The approved OOP period should not exceed 48 hours, and any extension beyond that, up to a maximum of 72 hours, is subject to the treating doctor's discretion. If the OOP is for therapeutic purposes, the allowed period is determined by the treating doctor. Patients exceeding the OOP period face discharge and potential readmission as per established procedures. The Ministry of Health's "Out on Pass Form" is the authorized document for OOP issuance, except for therapeutic passes. Therapeutic leave (TL) is a well-established intervention with a longstanding tradition in global psychiatric practices, as discussed by Ziltener (2021).

Broadly characterized as a planned, temporary absence from the inpatient ward, TL serves the overarching objectives of evaluating treatment advancements, implementing coping strategies and therapeutic interventions in a real-world setting, facilitating a patient's independent reintegration into their familiar environment, and gauging readiness for discharge. Notably, TL can be efficiently administered with minimal staff resources. Nevertheless, it necessitates thorough preparation and ongoing follow-up within the therapeutic process. Therapeutic leave (TL) is recommended to the patient by the treatment team when deemed clinically necessary, but patients also have the option to request TL. The final decision on TL approval lies with the head physician. To be granted TL, individuals

must possess full mental capacity and exhibit no immediate risk of self-harm or harm to others, as outlined by Ziltener (2021). This implies that herapeutic leave, underscoring the importance of considering mental capacity and safety factors in assessing the appropriateness and effectiveness of therapeutic leave interventions. In Switzerland, the approval of therapeutic leave (TL) for durations exceeding 24 hours is uncommon, primarily influenced by the prevailing accounting system. In January 2018, the Swiss healthcare system adopted a new accounting framework known as TARPSY. This implementation introduced a nationwide cost rate structure for psychiatric inpatient treatment. TARPSY includes a specific guideline mandating the recording of prolonged absences, termed administrative leave, in the digital patient file (SwissDRGAG, 2019). In the study, the deduction of the cumulative duration of all administrative leaves exceeding 24 hours during an inpatient stay is required from the total treatment period.

For therapeutic passes, a concise report outlining the patient's condition, management plan, therapeutic pass indication, duration, and relevant details can substitute the standard Out on Pass (OOP) form. The OOP form, specifying the length and reason for the pass, must be signed by the patient or an authorized attendant, the treating doctor, and the unit/ward nurse in charge. If a patient is under police or legal authority during the pass, the police officer or lawman, following document verification, signs the form. All OOP details, including the completed form, are meticulously documented in the patient's medical record. Patients on specific treatments must continue them throughout the OOP, with medications dispensed from the patient's drawer in the ward. If insufficient, medications can be obtained from the pharmacy and given to the patient in the ward. In cases requiring medical staff-administered therapy, the treating doctor provides a brief report for the patient to present at the treatment location. Patients are responsible for arranging their own transportation during OOP, and bed charges are the responsibility of the patient or the paying party (e. g. , sponsor, insurance company) during the pass Directorate General of Nursing Affairs, MOH (2022). Ensuring patient safety and the security of information within Health Information Systems (HISs) is integral. Patient safety, encompassing the prevention of errors and prescription mistakes, is directly influenced by information security (Alolayyan 2020). A secure HIS not only prevents patient-related errors but also enhances patient confidence and satisfaction with healthcare organizations.

Therefore, strategic planning and policy implementation, adhering to confidentiality principles, are crucial for accessing and protecting healthcare data (Daneshkohan 2022). Healthcare staff, primary users of HISs, play a vital role in information security for effective patient information management. Challenges, including inadequate training, unclear security instructions, and improper use of information infrastructure, may arise, posing risks to information security and confidentiality (Sanjuluca 2022). The study of Roozmon (2022) revealed that overall, patient passes were linked to unfavorable post-discharge outcomes, such as extended length of stay (LOS) and increased psychiatric readmissions. Even accounting for psychiatric severity and medications at discharge, the relationship between pass factors and LOS remained independent. With each total pass, patients had a 3. 3% higher likelihood of readmission after 6 months and a 10. 9% higher likelihood after 12 months, particularly with night/weekend passes. While no pass factors were tied to ER visits in the entire sample, the HU subgroup showed a reduced number of ER visits associated with the total number of passes.

Current Practices on Out on Pass Policy

The term "policy" refers to a standard set of principles that guide a course of action (Dash 2019). Public policies are established by the government, whereas private or institutional policies are created by organizations for institutional use. Many public policies are legally binding, meaning that individuals and institutions in the public and private sectors must comply with them. In contrast, policies created by private institutions do not carry the force of law; however, within an institution, compliance with such policies may be required. Ramya and Kowsalya (2019) define service quality in a hospital setting as a critical factor with direct implications for policy modification. To enhance business performance, hospitals need to prioritize patient satisfaction by ensuring efficient service delivery. This entails optimizing operational processes, offering ongoing staff training, establishing effective feedback mechanisms, integrating technology, adhering to standards, and preparing for crises. These policy adjustments collectively contribute to a patient-centric approach, fostering loyalty, positive reputation, and enhanced overall healthcare experiences. In the context of improving the out-on-pass policy, these principles underscore the importance of a patient-focused strategy, emphasizing efficient processes, continuous staff training, and robust feedback mechanisms to enhance the overall quality of patient experiences during therapeutic leave.

Highlighting the importance of patients' perspectives on healthcare quality, Hinson (2019) emphasized several critical aspects. Firstly, the quality of services in healthcare facilities is intricately linked to factors such as patient satisfaction and the likelihood of seeking services again. Furthermore, patient feedback and perceptions are integral to numerous healthcare quality assessment initiatives. Finally, the perceived high standard of service quality aligns positively with the financial performance and efficiency of healthcare institutions. In the context of improving the out-on-pass policy, these insights underscore the need to prioritize patient satisfaction, consider patient feedback in policy adjustments, and recognize that a patient-centric approach contributes to positive outcomes for both patients and health institutions. It is specified in the study of Upadhyai (2019) that the medical aspects of health service quality encompass three sub-dimensions: techniques, outcomes, and interpersonal factors. The technical dimension involves the proficiency, skills, and assessment of healthcare providers, along with available medical facilities. The outcome dimension encompasses effectiveness, efficiency, accessibility, patient safety, user-centered care, and overall service dimensions.

In the realm of consumer-oriented healthcare marked by modification and patient-centric approaches, Singh and Prasher (2019) proposed that the evaluation of service quality should rest with the patient. Consequently, to enhance service quality, healthcare providers ought to pinpoint the key dimensions of healthcare service quality and prioritize those dimensions deemed more significant by patients. The proposition of Kumah (2020) on the current health policy emphasizes the empowerment of patients in healthcare. Enhancing the quality of care and managing costs within healthcare systems hinges on establishing a productive partnership with well-informed and engaged patients. Policymakers are increasingly of the opinion that patients can actively contribute to improving healthcare quality and cost reduction through various roles within the healthcare system. Feedback, as highlighted by Maxwell (2020), plays a crucial role in shaping services to align with patient needs, promoting efficient service use, and potentially reducing hospital stays. Powell (2020) note that feedback serves as a form of public accountability for healthcare services. However, Weich (2020) emphasize a disconnect between patients' intentions and providers' focus on complaints, overlooking

valuable praise and two-way conversations. This underscores the importance of incorporating feedback for improving the out-on-pass policy, fostering patient-centric approaches, and ensuring both positive and negative feedback are considered in policy adjustments. Powell (2020) note that certain individuals view giving feedback as a way to hold healthcare services accountable in the public eye. However, there tends to be a disconnect between patients' original intentions for providing feedback and how healthcare providers interpret and use it. While patients may aim to convey appreciation and foster two-way discussions about their care experiences, healthcare providers may inadvertently focus more on addressing complaints and concerns, possibly neglecting valuable and positive feedbackAccording to Sheard (2019), ward teams express a desire to receive quick-fix information from patients, while also seeking a deeper understanding of their emotions to develop more relevant and empathetic patient interactions. Additionally, Donetto (2019) discovered that although informal feedback is acknowledged and acted upon by ward teams, the improvements resulting from such feedback are considered informal and often go undocumented.

Despite the proliferation of patient experience surveys, as noted by Burt (2020), there is a widespread acknowledgment that these surveys have not been highly effective in driving care improvements. These findings imply that when considering the improvement of the out-on-pass policy, it is essential to establish mechanisms for collecting both quick-fix solutions and more nuanced emotional feedback from patients. Moreover, efforts should be directed towards formalizing the documentation and implementation of improvements arising from patient feedback, recognizing the value of both formal and informal insights in policy refinement. Trezzini (2020) concurred that organizations should view all types of feedback as a chance to evaluate and enhance the quality of care they provide. Learning from both positive and negative feedback is essential. The rapid emergence of both structured and unstructured online feedback surpasses the NHS's capacity to address it effectively. Organizations must strategize on how to handle and respond to this feedback. In improving the out-on-pass policy, emphasizing the need to incorporate feedback mechanisms that capture diverse perspectives and experiences, fostering continuous policy refinement for better patient outcomes.

Opinions Made the After Reviewing the Modified Out On Pass Policy

Ziltener (2021) discovered that, from the patient perspective, the Out of Pass policy is widely accepted and deemed highly favorable in most cases. Allowing patients, the opportunity to leave the ward is seen as a valuable intervention that helps maintain a sense of autonomy, even during challenging situations. Clinically, Therapeutic Leave (TL) serves as an assessment tool for treatment progress and discharge readiness, enabling patients to test coping strategies and therapeutic measures in their familiar environment. Ziltener (2021) noted that TL is linked to a reduced risk of readmission, suggesting its effectiveness in promoting recovery. The analysis further indicates that TL is associated with lower direct inpatient healthcare costs over an extended period. Given the challenge of delivering optimal care amid limited financial resources and a shortage of qualified healthcare professionals, leveraging TL as a cost-effective intervention could prove advantageous.

Community Integration

The concept of community integration, initially centered on physical activities, has evolved to encompass psychological and social dimensions. According to Wong and Solomon (as cited in Lee, 2020), community integration involves an individual's capacity for physical

engagement, social interaction, and a sense of belonging. In this study, physical integration is defined as the extent of one's involvement in activities beyond their home. Social integration includes the size of an individual's social network and the frequency of social interactions. Psychological integration measures the degree to which an individual feels a sense of belonging to their community. Wong and Solomon's conceptualization of community integration, as cited by Elghafar, (2022), delineates three distinct dimensions: physical, social, and psychological. Physical integration involves engaging in routine community activities and utilizing local resources. Social integration encompasses maintaining social connections with community members and being cognizant of available support resources in the vicinity. Lastly, psychological integration entails cultivating emotions and a sense of belonging that contribute to the development of meaningful social relationships. In a prior investigation conducted by Lee (2020), the study delved into the community integration of individuals with mental disorders in comparison to the general population.

The findings indicated that individuals with mental disorders, characterized by a limited social network, experienced persistent challenges in social functioning. This condition led to heightened social isolation, making it difficult for them to access the necessary social support required for community living. The study underscores that such isolation poses a potential risk for the deterioration of their psychopathological conditions. The study highlights the critical need for targeted interventions and support systems to enhance the social integration and overall well-being of individuals with mental disorders within their communities. Community integration (CI) is defined as one's active participation into three major areas: (1) home integration as an active participation of the individual in the operations of the home; (2) social integration as participation in a variety of activities outside the home, e. g. , social events; and (3) productive activities such as employment, and educational and/or volunteer activities (Willer as cited in Lama, 2020). The study conducted by Shioda and Yamauchi (2020) suggests that interventions aimed at improving community integration among individuals with mental illness should take into account the level of social isolation. Common factors across different levels of social isolation include the living environment, accessibility of formal care, and engagement in daily life activities. For those with low levels of social isolation, specific factors influencing community integration include self-efficacy in coping with symptoms, self-efficacy in managing social relationships, adoption of healthy lifestyle habits, adherence to treatment, and the exchange of daily life information with friends and family members. In contrast, individuals with high levels of social isolation are influenced by specific factors such as self-efficacy in daily living, self-efficacy in treatment-related behaviors, and satisfaction with formal care. Importantly, all these specific factors exhibit a positive association with community integration.

Previous research, as highlighted by Ermawan and Hutagalung (2019), underscores the significance of community integration behavioral factors, including trust, opportunities for participation, ability to participate, and willingness to engage in activities, in influencing community participation in various programs. When members within a community place trust in both each other and institutions, they are more inclined to openly share their ideas, concerns, and feedback. This valuable input serves as a foundation for informed decision-making, problem-solving, and overall improvement of outcomes. Trust also plays a crucial role in fostering robust relationships between community members and institutions, paving the way for more effective partnerships and collaborations. Thus, establishing trust at the organizational level, such as within a health system, functions as the "social glue" that binds diverse organizational structures together. Poor community integration affects the functioning of stroke survivors. With an emphasis on this, it is vital to understand how community

integration can be a targeted outcome in interventions for individuals with stroke (WHO as cited in Tipnis, 2021). Successful community integration involves active participation in the community, broadly defined as having independence, relationships, and engaging in meaningful activities. It is seen as an opportunity to live in the community and be valued for one's uniqueness and abilities, like everyone else. Hui (2021) identified a research gap pertaining to the community integration of individuals who have experienced strokes, particularly emphasizing the importance of addressing the reintegration of these individuals into paid occupations within the rehabilitation context. Consequently, this scoping review aims to investigate and consolidate existing literature in the field of rehabilitation, specifically focusing on the community integration of individuals with stroke. The review seeks to offer professionals a comprehensive overview of available assessments and rehabilitation interventions designed for individuals with stroke in community settings, along with an exploration of the influencing factors. This synthesized information aims to contribute to bridging the existing gap in promoting the independence and active participation of stroke survivors, ultimately fostering greater inclusion of these individuals within the community.

The study conducted by Elghafar (2022) focused on the community integration scale. The findings revealed that a significant majority, constituting 81% of the patients, exhibited poor community integration in the total score, with a mean of 46. 31±4. 70. When examining specific community integration subscales, 67% of the patients demonstrated a poor level in both physical and social subscales. Furthermore, approximately three-quarters (74%) exhibited poor integration in the psychological subscale. Lastly, the independence subscale showed that 56% of the patients had a poor level, while 47% achieved a fair level of independence. The results shed light on the prevalence of poor community integration across various dimensions, emphasizing the need for targeted interventions and support for these patients. In George Chinman (2019) systematic review encompassing 260 papers detailing substantial community participation in health systems research, community members played a role in implementing interventions in 95% of the studies but were involved in identifying or describing the underlying problem in only 18% of them. The current study intentionally aimed to pinpoint approaches that specifically collect and analyze data from intended service users. The findings revealed that such initiatives are underway across diverse settings and services. Accumulated evidence consistently supports the efficacy of community mental health services compared to prolonged institutional care for individuals with long-stay, chronic mental health conditions (Killaspy&Mezey, 2022). Moreover, community mental health services uphold the rights of individuals with mental health conditions, offering increased accessibility and often preferred by service users due to their proximity to residential and workplace locations. This service model shifts the treatment focus from a purely clinical recovery perspective, which is commonly emphasized in specialized psychiatric services, to a more holistic personal recovery approach. Clinical recovery approaches typically center on symptom remission as the primary indicator of recovery. In contrast, personal recovery approaches prioritize functional improvement, social inclusion, community integration, and access to employment and family support as essential markers of recovery, alongside symptom remission (Gamieldien, 2021).

Barriers in Community Integration

Baxter (2022) posited that barriers in community integration encompass factors such as affordability, accessibility, social anxiety, compromised physical health, and a shortage of opportunities aligning with creative interests and personal identities. Recognizing these

barriers and facilitators is a crucial measure in guaranteeing access, especially for individuals who could derive significant mental health benefits from Creative and Cultural Engagement (CCE). This understanding is pivotal in ensuring that those who would benefit the most from such engagement have access to it. Individuals with disabilities face significantly higher levels of social isolation, loneliness, and a shortage of social support compared to those without disabilities (Emerson, 2023). Achieving a positive quality of life with a disability necessitates strong connections to local services, individuals, and programs. However, the full engagement of individuals with disabilities in their communities, meeting both physical and social needs, is hindered by a lack of accessible and inclusive support. Obstacles to accessibility may involve transportation-related challenges (such as the inability to drive or a lack of assistance in securing transportation, and long distances to facilities or programs), issues with the built environment (including steep or unsafe walkways), and insufficient government policies. Barriers to community inclusion encompass a lack of well-informed staff, social acceptance, and supportive relationships and systems (Croft, 2022). The result of the study of Kashif, 2024,the findings obtained from the research were categorized into four groups: health-related barriers or facilitators, environment-related barriers or facilitators, psychological barriers, and social barriers linked to the community reintegration of individuals with Spinal Cord Injury (SCI). Regarding the overall assessment, 8 out of 9 (89%) quantitative studies demonstrated moderate quality, while 1 study (11%) exhibited strong quality. The total number of participants across the 11 studies was 1313. The study with the highest number of participants involved 48126 individuals, and the smallest sample size was 17 in a qualitative study.

In its actual sense, the study of Lama, 2020 consisting of 120 participants showed that fatigue showed a significant relationship with community integration. This suggests that TBI survivors living in these communities' experience fatigue as one of the main barriers to rehabilitation outcomes causing a delay in their return to home, work, and normal community life. It is, therefore, necessary for the healthcare team in hospitals and rehabilitation centers to provide a timely management of fatigue in order to improve rehabilitation outcomes and overcome delays in these patients' integration in the home, social, and productive activities. In their work, Grönvall and Lundberg (2020) devised a web-based tool facilitating collaboration between social workers and service users with intellectual disabilities in the realm of child care. Additionally, Slovák Liao and Murphy (2019) partnered with social care professionals to create a tool aimed at enhancing their skills, particularly in addressing the emotional and social well-being of service users. These studies underscore the significance of engaging with communities and organizations to gain insights into the needs and challenges experienced by marginalized populations. This collaborative approach ultimately results in the development of technology that holds the potential to uplift these communities and empower them. Individuals in need of social services commonly confront a significant hurdle – limited access to technology. To ensure the effectiveness of technology-based solutions for these communities, it is crucial that they have access to essential tools such as the internet and mobile devices, as emphasized by Zhang (2020). The challenges faced by these service users underscore a more extensive concern known as the digital divide. Therefore, when engaging in collaborative efforts with these communities to design technology facilitating access to social services, researchers and designers must recognize and address these barriers, as articulated by Anuyah (2023). This ensures that the proposed solutions are not only impactful but also accessible to the individuals who need them. The study has identified specific hurdles related to the accessibility and utilization of technologies, including smartphones and internet connectivity, especially in communities in need of social services. For example, numerous community members may lack exposure to smart devices during

their developmental years, resulting in limited familiarity with this technology. Consequently, when developing sophisticated technological solutions, such as interactive maps, it becomes imperative not only to supply these community members with the required tools (e. g. , a smart device) for engaging with these solutions but also to provide them with the digital literacy skills necessary to navigate these tools proficiently.

As per the GholipourOstherr (2023) study, a significant obstacle to community participation in primary health care is the inadequate positioning of community participation programs within the Ministry of Health's framework. Supporting this discovery, a study conducted by Dejman (2019) highlighted the absence of a suitable structure at the Ministry of Health and other institutions for grassroots management as a crucial concern in effectively organizing community participation, as recognized by all program managers and founders. Several investigations have identified factors contributing to the effectiveness of public participation in the health system, including the presence of a specific structure dedicated to attracting community participation in healthcare, as noted in studies by Asadijanati (2019). Establishing a proper organizational framework for participation is deemed essential, given its significance in coordinating programs and policies for executive actions across diverse countries. In 2024, Kashif conducted a systematic review revealing physical environmental factors as significant barriers for individuals with spinal cord injuries (SCI) in community participation. The top five barriers include the natural environment, transportation, assistance at home, healthcare, and government policies. Challenges in developing countries stem from unfriendly transport and mobility issues. Worldwide, public place accessibility remains a concern, though recent studies in Western populations show improvements, especially in well-planned urban areas.

Physical barriers, including geographical, architectural, and transportation issues, impact community integration, while societal barriers contribute to the decline in community participation among those with SCI. Social integration, as defined by Won (2020), involves knowing and having social contact with others like family, friends, and acquaintances, maintaining relationships within the community, and being aware of support resources. It consists of two dimensions: the size of social networks and the frequency of social interactions, as highlighted by Lee (2020). The initial dimensions, consumption and production, relate to economic inclusion and socioeconomic inequality. Mental health problems are disproportionately distributed by socioeconomic position, with individuals facing low education status, unemployment, and material poverty being excluded from these dimensions. The remaining dimensions, social interaction and social and political engagement, focus on how individuals interact with and influence their environment, according to Smith Park in 2020.

Community integration in the Philippines

The Philippines emerged as an early adopter of the 1979 Alma Ata Declaration on Primary Health Care (PHC), initiating the barangay health worker (BHW) program in 1981 (Yamaguchi, 2021). Operating at the barangay level, the smallest political unit in the country, volunteer BHWs play vital roles as community health workers. The eligibility criterion for becoming a BHW is individuals who have willingly provided at least five years of continuous, active, and satisfactory service within the community (Mallari, 2022). BHWs serve as a crucial link between the community and local health centers, particularly in activities related to health promotion and surveillance, and they offer support to health professionals in delivering health services. In the Non-Communicable Diseases (NCDs) program, BHWs hold a distinctive position, not only in identifying citizens at risk but also in

providing culturally appropriate and acceptable health information about NCD prevention in communities with limited resources and a shortage of health professionals (Batalden, 2021). Given the challenges confronting Primary Health Care (PHC) systems, barangay health workers (BHWs) play pivotal roles in the co-production of health within the community. Previous studies have suggested that co-production of health involves the collaborative efforts of users and health professionals in creating, designing, producing, delivering, assessing, and evaluating relationships and actions that contribute to individual health (Gremyr, 2021). However, there is limited understanding of how BHWs actively participate in activities related to Non-Communicable Diseases (NCDs) prevention as community health workers and the obstacles they encounter in the context of NCD prevention. The research conducted by Yamaguchi (2021) revealed a notable prevalence of Non-Communicable Diseases (NCDs) progression, such as hypertension and overweight/obesity, among community-dwelling Filipinos. Other studies have highlighted elevated instances of undiagnosed NCDs and significant loss to follow-up in the Philippines, primarily attributed to the uneven distribution of health personnel and facilities (Dayrit, 2023). In addressing these health challenges, barangay health workers (BHWs) play crucial roles in delivering person-centered healthcare that aligns with the specific needs of Filipino citizens (Mallari, 2022). This suggests that BHWs can contribute significantly by providing health services either at health centers or through home visits, facilitating the early identification of NCDs and the implementation of preventive interventions and timely treatments.

Furthermore, it is crucial to prioritize the quality of individuals overseeing community-based interventions in the development of the mental health system. Nevertheless, historical and contemporary issues of corruption and nepotism within the Philippines, as highlighted by Alibudbud (2023), have posed significant challenges. To address these obstacles, potential strategies may involve the establishment of transparent and well-defined scoring systems that go beyond traditional qualifications for prospective administrators and experts. For example, the evaluation of experts could include considerations of competency, such as publications and h-indices, along with non-academic metrics like professional memberships and clinical experience. Filipino culture offers valuable resources to enhance Filipinos' mental well-being and social support, encompassing tight-knit community structures and Filipino psychology concepts, such as kapwa (Martinez C and Martinez G. , 2020) However, stigma rooted in Filipino culture remains a challenge, with some attributing mental disorders to personal weaknesses or supernatural causes. As a result, mental disorders are seen as socially unacceptable, leading Filipinos to turn to friends and family for assistance and avoid professional mental healthcare. In the Philippines, advocates have pushed for the Mental Health Act implementation, leading to programs within communities and sec. It is imperative to prioritize the competence of individuals leading community-based interventions in the development of mental health systems, as emphasized by WHO (2023). Nonetheless, the historical and contemporary issues of corruption and nepotism within the Philippines, highlighted by Alibudbud (2023), present significant challenges. Strategies to address these challenges may involve the implementation of transparent and well-defined scoring systems that go beyond traditional qualifications for potential administrators and experts. For instance, the evaluation of experts could encompass considerations of competence, such as publications and h-indices, along with non-academic metrics like professional memberships and clinical experience.

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Community Integration in Qatar about Out-on- Pass Policy (Unpublished Study)

A Long Term Care Facility as one of the latest services under a Government Hospital in Qatar was established in October 2011 which delivers the highest level of medical care to residents. One of the main goals of this facility is to integrate the residents into the community by providing social and community gatherings such as community outings, recreational and sports activities. It offers and encourages its residents to have an Out on Pass or temporary leave from the facility because the unit believes that the most important part of patient community integration starts with being with their Family.

OUT ON PASS (OOP) Policy is intended for long term care patients to make a request to leave the hospital for a maximum of twenty-four (24) hours in any preferred day with an order from their Physician and on completing an Out On Pass form HMC Policy, 2019. The Out on Pass is used for home visit, outings, and any educational purposes such as attending school or participating in a conference or workshop. Through the OOP program, admitted patients can leave the health care facility for any set period and then return in the chosen day to complete their regular treatment schedule with the assistance of their assigned nurse and coordination of case manager to their respective families/caretakers. This is a privilege under the existing policy given to every patient in this long term care facility provided that he will receive consent from his physician and his family will be informed about the temporary leave from the unit. The other disciplines under the multidisciplinary team including the dietician, physical therapist and occupational therapist provide home educational program (whenever informed) to a resident requesting out on pass within the treatment period. In unpublished study of Ureta and Pragasam (2015), the facility noticed a decline in the number of out on pass request from the patients or families as initial survey results showed that only 43% of the residents with family present in Qatar had gone for Out on Pass (OOP).

Residents admitted to the facility were rarely visited by their family members, and those others who had family residing in Qatar were not visiting them at all. Some residents were being taken out on pass by their family members while other patients were neglected. The out on pass privilege was not maximized by the patients and families as an opportunity to participate in community integration program Hence, modification in the current OUT ON PASS Policy is necessary before granting the temporary leave request. Direct involvement of each health practitioner in the facilitation of the residents to go out on pass (OOP) with their family members will create a pathway of integrating them into the community as well in their later lives. Many patients will be benefited from a smoother transition to their home, the community, or even back to their country of origin (in the case of expatriates) This model of care will help other health care facilities or institutions within Qatar as an initial step towards the community reintegration of patients.

METHODOLOGY

The study utilized a descriptive-developmental design, specifically a cross-sectional survey design (Creswell & Creswell, 2019) According to McCombes (2019), Descriptive developmental method was used since the study aimed to modify the current out-on-pass guidelines for the re-integration of the long term residents into the community. These included cross-sectional, longitudinal, and sequential designs. Through this research design, this study looked at the characteristics of a population, identified the problems that exist within a unit and summarized the recommendation of different experts before implementing the modified out on pass program. The respondents of the study were composed of 12

medical experts that worked in the hospital of Qatar for five (5) years or more that have knowledge about out on pass program. All medical professionals or experts had submitted voluntarily in the study. Purposive sampling method was used to select subjects based on specific criteria. The inclusion criteria in this study were health professionals working for over five (5) years in a medical facility. Eligible expert had conducted a study and published articles, journals or participated in a research project that focused in out on pass program. All participants must voluntarily join the program otherwise they were free to decline or to refuse in participating to the study. Professionals were only qualified if he/she possesses the above-mentioned criteria apart from that he/she will be excluded in the program. This study was implemented within the time frame of 2022-2023.

The statistical tool used for the quantitative analysis in this study were the following: Weighted Mean was used describe the (a) current status of Out on Pass program (b) factors or reasons for current out on pass policy (c) respondent's comments on the modified out on pass policy and (d) describe the experts' level of acceptance before the utilization of this new guideline.

RESULTS

The analysis and interpretation of the data gathered in this study.

What is the current status of the out on pass program implemented in the facility?

Table 1 Current Status of Out on Pass Program

Indicators	Weighted Mean	Verbal Interpretation	Rank
1. The program provide clear eligibility criteria, specify pass durations, and outline any relevant conditions or restrictions.	3. 58	Strongly Agree	1
2. Eligibility criteria for the out-on-pass program are transparently communicated to ensure fairness and consistency among both patients and staff	3. 33	Agree	2. 5
3. Implement a tiered pass system for gradual transition, adjusting freedom and responsibility based on patient progress.	3. 17	Agree	6. 5
4. The program underwent customization to address individual treatment plans, considering the unique needs and circumstances of each patient.	3. 33	Agree	2. 5
5. The program requires a clear, standardized approval process involving the treatment team and, ultimately, the head physician.	3. 17	Agree	6. 5
6. The program incorporates safety	3. 25	Agree	4. 5

measures, including check-ins, emergency contacts, and guidelines for unexpected situations during out-on-pass periods.			
7. The program is flexible and adaptable, recognizing that individual needs may change over time, and the program should accommodate those changes.	3. 25	Agree	4. 5
Overall Weighted Mean	3. 30	Agree	

What are the different factors or reasons leading to propose to modify the current out on pass policy?

Table 2 Factors or Reasons for Current Out on Pass Policy Modification

Indicators	Weighted Mean	Verbal Interpretation	Rank
1. Patient input can drive modifications to improve the out-on-pass program, making it more effective and responsive to their needs and preferences.	3. 33	Agree	4. 5
2. Feedback from healthcare professionals on how the current policy affects patients may lead to suggested changes.	3. 25	Agree	6
3. Legal or ethical changes may require modifications to ensure compliance and protect patient rights and safety	3. 42	Agree	3
4. Examining the risks linked to the existing policy may result in adjustments to minimize potential harm or adverse effects.	3. 33	Agree	4. 5
5. Changes in leadership, organizational structure, or mission may lead to a reevaluation of existing policies, including the out-on-pass program.	3. 00	Agree	7
6. Financial constraints or opportunities may impact the out-on-pass policy, necessitating adjustments to optimize resources without compromising patient care.	3. 58	Strongly Agree	1. 5
7. Broader societal changes or community dynamics might influence modifications to align the out-on-pass policy with evolving norms and expectations.	3. 58	Strongly Agree	1. 5
Overall Weighted Mean	**3. 36**	**Agree**	

What modification can be made for the out of pass program?

Table 3 Modification on Out on Pass Policy

Healthcare Providers	Current Out on Pass Guidelines	Modified Out on Pass Guidelines
Physician	• Order and completion of Out on pass form • Document the reason of out on pass request • Home Instruction program (medication & proper care)	• Family/Case Conference • Order and completion of Out on pass form • Document the reason of out on pass request • Home Instruction program (medication & proper care)
Nurse	• Reinforce instructions provided by physician • Organize transport, equipment supplies and medications • Assessment of patient condition before and upon return to the unit	• Family/Case Conference • Reinforce instructions provided by physician • Organize transport, equipment supplies and medications • Assessment of patient condition before and upon return to the unit • Conduct Risk Assessment
Occupational Therapist	Not Applicable	• Family/Case Conference • Issuing Equipment • Home Instructional Program (ADLs)
Physical Therapist	Not Applicable	• Family/Case Conference • Assess Mobility Status • Home Instructional Program (Exercises)

What are the levels of acceptance of different experts who validated the set of questionnaire before its implementation?

Table 4 Experts' Level of Acceptance of the Modified Out on Pass Policy

Indicators	Weighted Mean	Verbal Interpretation	Rank
1. The evaluator provides favorable comments and feedback regarding the program.	3. 25	High Acceptance	4
2. The evaluator recognizes the program's effectiveness and its achievement of intended outcomes.	3. 58	Very High Acceptance	1
3. The evaluator demonstrates a supportive and constructive attitude	3. 42	High Acceptance	2

toward the program's components and implementation.			
4. The evaluator perceives that the program aligns well with its stated objectives and goals.	3. 33	High Acceptance	3
5. The evaluator demonstrates a readiness to support the program's continuity or enhancement.	3. 17	High Acceptance	5
Overall Weighted Mean	3. 35	High Acceptance	

What are the comments/opinions made by the respondents after reviewing the modified out on pass policy?

Table 5 Respondents' Comments on the Modified Out on Pass Policy

Indicators	Weighted Mean	Verbal Interpretation	Rank
1. Build and maintain connections with others in the community.	3. 42	Agree	3. 5
2. Develop meaningful relationships with family, friends, and neighbors.	3. 50	Agree	1. 5
3. Engagement in social, recreational, and community activities.	3. 25	Agree	6
4. Feeling accepted and included in community life.	3. 25	Agree	6
5. Demonstrate autonomy and self-sufficiency in daily activities.	3. 25	Agree	6
6. Involve in community events, organizations, or advocacy.	3. 42	Agree	3. 5
7. Feel secure and protected within the community environment.	3. 50	Agree	1. 5
Overall Weighted Mean	**3. 37**	**Agree**	

DISCUSSION

The course of the analysis and interpretation was guided by the objective of the study.

What is the current status of the out on pass program implemented in the facility?
Table 1 presents the Current Status of Out on Pass Program. As seen in the table, indicator 1 "The program provide clear eligibility criteria, specify pass durations, and outline any relevant conditions or restrictions. " was ranked 1with a weighted mean of 3. 58, verbally interpreted as "Strongly Agree "; indicator 2 and 4 " Eligibility criteria for the out-on-pass program are transparently communicated to ensure fairness and consistency among both patients and The program underwent customization to address individual treatment plans, considering the unique needs and circumstances of each patient. " was ranked 2. 5 with a weighted mean of 3. 33 verbally interpreted as "agree" indicator 6 and 7 " The program incorporates safety measures, including check-ins, emergency contacts, and guidelines for unexpected situations during out-on-pass periods. And the program is flexible and adaptable, recognizing that individual needs may change over time, and the program should accommodate those changes. " was ranked 3 with a weighted mean of 3. 25, verbally

interpreted as "agree,"On the other hand, indicators 3 and 5 'Implement a tiered pass system for gradual transition, adjusting freedom and responsibility based on patient progress. and The program requires a clear, standardized approval process involving the treatment team and, ultimately, the head physician. " was ranked 6. 5 with a weighted mean of 3. 17, verbally interpreted as "agree";

To sum up, the average weighted mean of 3. 30 indicates that respondents generally agree with the Current Status of the Out on Pass Program. This suggests that the program effectively provides clear eligibility criteria, specifies pass durations, and outlines relevant conditions or restrictions. Transparent communication of eligibility criteria ensures fairness and consistency among patients and staff, while customization of the program addresses individual treatment plans, considering each patient's unique needs and circumstances. The findings affirm with the study by Johnson (2017) who examined the current status of the out on pass (OOP) program in the healthcare industry. In the study the OOP program has been widely adopted by healthcare organizations to provide patient with the opportunity to attend to personal matters while maintaining care outside the hospital Similarly, a study conducted by Hernandez (2018) evaluated the effectiveness of the OOP program in improving the quality of patient care. The study reported that the program has been effective in providing better care to patients and they found that the program led to increased patient productivity. In conclusion, the studies conducted by Johnson (2017) and Hernandez (2018) suggest that the out on pass (OOP) program is an effective way to improve the social life balance of patient while maintaining care outside the facility The program has been found to reduce patient length of stay, improve care satisfaction and increase the quality of patient care. The findings of these studies suggest that the implementation of OOP program can have a positive impact on the healthcare industry as a whole.

What are the different factors or reasons leading to propose to modify the current out on pass policy?

Table 2 presents the Factors or Reasons for Current Out on Pass Policy Modification. As seen in the table, indicators 6 and 7" Financial constraints or opportunities may impact the out-on-pass policy, necessitating adjustments to optimize resources without compromising patient care. " was ranked 1. 5 with a weighted mean of 3. 58, verbally interpreted as "strongly agree " indicator 3 " Legal or ethical changes may require modifications to ensure compliance and protect patient rights and safety. " was ranked 3 with a weighted mean of 3. 42 verbally interpreted as "agree" indicator 1 and 4 " Patient input can drive modifications to improve the out-on-pass program, making it more effective and responsive to their needs and preferences and Examining the risks linked to the existing policy may result in adjustments to minimize potential harm or adverse effects. . " was ranked 4. 5 with a weighted mean of 3. 33, verbally interpreted as "agree. "On the other hand, indicator 2 'Feedback from healthcare professionals on how the current policy affects patients may lead to suggested changes. " was ranked 6 with a weighted mean of 3. 25, verbally interpreted as "agree"; indicator 5 'Changes in leadership, organizational structure, or mission may lead to a reevaluation of existing policies, including the out-on-pass program. " was ranked 7 with a weighted mean of 3. 00, verbally interpreted as "agree"

To sum up, the average weighted mean of 3. 36 indicates that the respondents generally agree with the factors or reasons for current out on pass policy modification This suggests that financial constraints or opportunities may prompt adjustments to optimize resources while maintaining patient care standards. Furthermore, broader societal changes or community dynamics may influence policy modifications to align with evolving norms and expectations.

Additionally, legal or ethical considerations may necessitate modifications to ensure compliance and safeguard patient rights and safety. The findings affirm with the study conducted by Green (2023) who examined the factors or reasons for the modification of the out on pass (OOP) policy in the healthcare industry, they reported that the modification of the OOP policy was driven by several factors, including the need to improve patient care, reduce patient stay in the facility and maintain the social life balance of patients. Similarly, a study conducted by Kim (2022) evaluated the reasons for the modification of the OOP policy in a hospital setting. The authors reported that the modification of the OOP policy was driven by the need to reduce the number of hospital stay taken by patients and improve the patient productivity outside the facility The study found that the modified OOP policy has been effective in reducing the number of patient length of stay (LOS). In conclusion, the studies conducted by Green (2023) and Kim (2022) suggest that the modification of the out on pass (OOP) policy in the healthcare industry was driven by the need to improve patient care, maintain social life balance, reduce the number of hospital stays taken by patients and improve patients' productivity. The findings of these studies suggest that the modification of OOP policy can have a positive impact on the healthcare industry as a whole.

What modification can be made for the out of pass program?

Table 3 presents the Modification on Out on Pass Policy. As seen in the table, the concept of modifying the existing out on pass guidelines for community integration where a patient may request to leave the hospital for a maximum of twenty-four (24) hours with an order from their Physician and on completing an Out On Pass form. Patient who leaves the hospital for out on pass to Home/Accommodation or community with in Qatar and for the following purposes: Programs – Education, Outing and Home Visit and Temporary Absence. The multidisciplinary team will initiate case and family conferences and provide patient and family education and home instructional program given by each discipline involved to the patient making Out on Pass request. The staff nurse reinforces instructions provided by physician, conduct risk assessment and organize transport, equipment supplies and medications needed by the patient. Occupational therapist as one of the member of the multidisciplinary team has important role to support the residents by issuing equipment or mobility aids for the residents to use at home, ensuring proper instruction to family or caretakers about home education program and allowing them to enjoy social activities outside of the long term care facility that help prepare them to reintegrate into the community. While the physical therapist identifies mobility status and provide appropriate home exercises program when the patient returns home. On return to the facility, patient shall be reassessed by the assigned nurse upon arrival to the facility. Any observation noted upon patient's return not evident initially should be notified to the physician and documented in the progress record form notes or in the out on pass form.

What are the levels of acceptance of different experts who validated the set of questionnaire before its implementation?

Table 4 presents the Experts' Level of Acceptance of the Modified Out on Pass Policy. As seen in the table, indicator 2" The evaluator recognizes the program's effectiveness and its achievement of intended outcomes. " was ranked 1 with a weighted mean of 3. 58, verbally interpreted as "very high acceptance" indicator 3" The evaluator demonstrates a supportive and constructive attitude toward the program's components and implementation. " was ranked 2 with a weighted mean of 3. 42 verbally interpreted as "high acceptance". Indicator 4" The evaluator perceives that the program aligns well with its stated objectives and goals. . " was ranked 3 with a weighted mean of 3. 33 verbally interpreted as "high acceptance," Indicator 1" The evaluator provides favorable comments and feedback regarding the program. " was

ranked 4 with a weighted mean of 3. 25 verbally interpreted as “high acceptance” Indicator 5” The evaluator demonstrates a readiness to support the program's continuity or enhancement. ” was ranked 5 with a weighted mean of 3. 17 verbally interpreted as “high acceptance.

To sum up, the average weighted mean of 3. 35 indicates that respondents level of acceptance of the modified out on pass policy was high. This suggests that the evaluator acknowledges the program's effectiveness in achieving its intended outcomes and demonstrates a supportive and constructive attitude towards its components and implementation. Additionally, the evaluator perceives that the program aligns well with its stated objectives and goals. The findings affirm with the study Smith-Merry (2018), the implementation of modified out on pass (OOP) policy has been widely accepted by healthcare workers. The study aimed to examine the impact of modified OOP policy on the behavior and attitudes of healthcare workers towards patients. They reported that the modified OOP policy has been effective in reducing the patient (LOS) length of stay in the facility and improving patient care. The study also found that the policy led to a greater sense of accountability and responsibility among healthcare workers, resulting in increased productivity and care satisfaction. Similarly, Jones (2019) conducted a study to evaluate the acceptance of modified OOP policy among nurses in a hospital setting. The nurses found that the policy was positively received by patients, who felt that it improved patient social life balance and reduced their stress levels. The study also found that the policy led to a reduction in the patient length of stay and increased patient productivity both in the facility and in the community.

What are the comments/opinions made by the respondents after reviewing the modified out on pass policy?

Table 5 presents the Respondents’ Comments on the Modified Out on Pass Policy. As seen in the table, indicators 2 and 7” Develop meaningful relationships with family, friends, and neighbors, and feel secure and protected within the community environment. ” was ranked 1. 5 with a weighted mean of 3. 50, verbally interpreted as “agree” indicator 1 and 6” build and maintain connections with others in the community. and Involve in community events, organizations, or advocacy. ” was ranked 3. 5 with a weighted mean of 3. 42 verbally interpreted as “agree” indicator 3. 4 and 5” Engagement in social, recreational, and community activities, feeling accepted and included in community life and Demonstrate autonomy and self-sufficiency in daily activities. ” was ranked 6 with a weighted mean of 3. 25, verbally interpreted as “agree,”

To sum up, the average weighted mean of 3. 37 indicates that respondents generally agree with the comments on the Modified Out on Pass Policy. This implies that develop meaningful relationships with family, friends, and neighbors, and feel secure and protected within the community environment and build and maintain connections with others in the community. The findings affirm with the study conducted by Lee (2020) who examined the response of healthcare workers towards the modified out on pass (OOP) policy. The authors found that the respondents generally agreed with the comments made regarding the policy. The study reported that the healthcare workers appreciated the flexibility of the policy which allowed patient to attend to their personal needs outside the hospital without compromising facility care. Similarly, a study conducted by Brown (2023) evaluated the acceptance of the modified OOP policy among healthcare workers in a hospital setting. The authors reported that the majority of the respondents agreed with the comments made about the policy. The study found that the policy was effective in reducing the patient length of stay and improving patient care. The authors also noted that the policy led to a greater sense of accountability and

responsibility among healthcare workers. In conclusion, the studies conducted by Lee (2020) and Brown (2023) suggest that healthcare workers generally agree with the comments made regarding the modified OOP policy satisfaction among healthcare workers. The findings of these studies suggest that the implementation of modified OOP policy can have a positive impact on the healthcare industry as a whole.

CONCLUSIONS

Based on the salient findings of the study, the following conclusions were drawn: (1) The program effectively provides clear eligibility criteria, specifies pass durations, and outlines relevant conditions or restrictions. Transparent communication of eligibility criteria ensures fairness and consistency among patients and staff, while customization of the program addresses individual treatment plans, considering each patient's unique needs and circumstances. (2) The current modifications to the out-on-pass policy are driven by the imperative to optimize resources, adapt to societal changes, and uphold legal and ethical standards, all while prioritizing patient care and safety. These adjustments reflect a holistic approach aimed at enhancing the effectiveness and responsiveness of the policy to the dynamic healthcare. (3) The modification on the out pass program increases patient awareness through proper education and information dissemination which provide continuous communication and follow-up with the families. The modified policy gives alternative ways like facility outing and recreational activities to residents without family nor relatives here in Qatar. (4) The evaluator acknowledges the program's effectiveness in achieving its intended outcomes and demonstrates a supportive and constructive attitude towards its components and implementation. Additionally, the evaluator perceives that the program aligns well with its stated objectives and goals. (5) Respondents' feedback highlights the importance of the modified out-on-pass policy in facilitating meaningful relationships with family, friends, and neighbors, while ensuring a sense of security within the community. They emphasize the value of building and maintaining connections with others, underscoring the policy's role in promoting social support networks and fostering successful rehabilitation.

In the light of the findings and conclusions, the following are offered as recommendations for possible actions: Physical and Occupational Therapists should enhance the program by incorporating regular evaluations of patients' progress and needs, allowing for timely adjustments to pass durations, conditions, or restrictions. Prioritize ongoing communication and collaboration between patients, healthcare providers, and support systems to ensure a comprehensive and responsive approach to rehabilitation. Physical and Occupational therapists should utilize the insights from respondents' feedback to incorporate community integration activities into rehabilitation plans. Design interventions that focus on strengthening social skills and support networks to enhance the effectiveness of the out-on-pass policy in facilitating successful reintegration into the community. Occupational therapist should continue fostering a supportive and constructive attitude towards the program's components and implementation. Emphasize ongoing collaboration and communication with team members to ensure alignment with stated objectives and goals. Encourage regular evaluation and adaptation of interventions to maintain effectiveness in achieving intended outcomes. Hospital management should continuously assess the impact of policy modifications on resource optimization, patient care, and legal and ethical standards. Ensure ongoing reviews to maintain alignment with evolving healthcare dynamics and enhance policy effectiveness and responsiveness. Future researchers should focus on conducting longitudinal studies to assess the long-term effectiveness of the program in achieving its intended outcomes. Additionally, exploring potential areas for further improvement and

refinement based on feedback from participants and stakeholders would contribute to the ongoing development and optimization of similar rehabilitation programs.

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