

Early Experiences of a Large Integrated Health Care System: Engaging Hospices in Quality Measurement and Improvement

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Introduction

There were 48 studies total. Techniques to improve design, recruiting, involvement, and leadership action, as well as those targeted at building a receptive context, were thematically grouped, and they were tied to strategies and contextual elements that promote patient engagement. The outcomes that were reported included improved governance, improved care processes, and informed policy or planning documents (discrete products) (care process or structural outcomes). The degree of engagement seems to have an impact on the results of service redesign, with discrete products primarily deriving from low levels of engagement (consultative unidirectional input) and care process or structural outcomes primarily deriving from high levels of engagement (co-design or partnership strategies). Only a small percentage of research (n = 12; 25%) explicitly assessed patients' perceptions of the engagement process [1].

One health care system's attempt to enhance hospice care for its patients through the development of the RFI quality assessment and the initial iteration of the Partners hospice collaborative network is the systematic and fair evaluation and selection of hospices in a blinded manner based on a novel quality measurement tool created through expert consensus and previously studied quality metrics. The RFI method and scoring system created to accomplish this purpose imply that differentiation is conceivable. The goal of healthcare organisations is typically to increase patient engagement, which has emerged as a key component of high-quality care. This involvement has traditionally, and frequently, concentrated on the interaction between patients and clinicians in deciding on care or how to strengthen patients' efforts to control their own care. To better or rethink service delivery by incorporating patient experiences, there are growing initiatives to integrate patients in more ways. These initiatives are partly attributable to a growing understanding and acceptance that consumers of health services have a legitimate role, the necessary knowledge, and a significant impact on the planning and provision of services [2].

Description

In the red section of Carman's framework, where patients are actively involved as partners or co-leads in organisational re-design and evaluation of health care delivery, some experts urge governments and health care institutions to engage patients and other service users, including caregivers and relatives, in more robust ways. Although there is a sizable corpus of research on patient engagement techniques and their impact on patients and health services, the material is scattered and has not recently been compiled into a comprehensive overview. Effective techniques and the contextual variables

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that support their outcomes are required if the advantages of involving patients in the design or delivery of health care are to be realised at an organisational or system level. The tactics for actively including patients and families in improving or redesigning health care, as well as the contextual elements impacting the results of these efforts, were the subject of a systematic review of the international English-language literature [3].

In the US, there is still a wide range in the quality of hospice care. The quality of care delivered by a specific hospice cannot be fully assessed by patients, healthcare practitioners, or health care institutions. Partners HealthCare wanted to evaluate the quality of hospice care using objective and quantitative standards that were received from hospices themselves and through open reporting. Here, we go over how to create and use this assessment as well as how to start a working relationship with top-notch hospices. The criteria and rating system were designed by a multidisciplinary advisory council, focused on organisational data (such as nursing turnover), clinical care quality indicators (such as visit hours before death), training (such as medical director certification), and satisfaction [4].

To address our focused research questions, we used a thorough strategy in our systematic search and included all empirical qualitative, quantitative, and mixed methodologies study designs across all contexts of care. Given that we included qualitative and quantitative research (to represent the breadth of studies in this field), used a thematic analysis (given the plurality of designs), and performed a quality rating, our study did not fit into typologies of literature reviews. The PRISMA reporting guidelines for systematic reviews and meta-analyses were followed. Studies were considered for inclusion if they were publicly accessible empirical articles that specifically examined the involvement of patients, caregivers, or families in the design, delivery, and evaluation of health services. This aligns with involving patients in organisational design and governance, as shown in Carman's framework or partnering with them or sharing leadership with them. Only English-language papers using qualitative, quantitative, or mixed methodologies and published between January 1990 and March 2016 were included in the searches. We choose 1990 because it was at this time when patient engagement, notably in mental health facilities, and the larger discourse on the quality of care began to take off.

All care environments qualified. Articles that did not specifically address patient engagement were also disregarded, as were those that did not address the more comprehensive design, delivery, and evaluation of includes information about the study's population, setting (i.e., country), objectives, methodology, and results. Continuum of patient involvement studies were then grouped according to the degree of patient engagement. We concentrated on studies that used co-design or those that consulted patients but also used elements of co-design, i.e., the more active levels of engagement on the Bates and Robert continuum, in keeping with our goals to review strategies for actively engaging patients and families in improving or redesigning health care. Changes or results of patients' engagement were categorised by us. The results of patient engagement were categorised as "quality of care outcomes" and the effects on patients as "patients experience outcomes". Results relating to the quality of care were divided into three categories: creating educational materials or tools for services, influencing planning or policy papers, and improving services or governance. Using a quality rating instrument that systematically evaluates various types of evidence and procedures on a scale from "very poor," "poor," "fair," and "good" which reflected the mixed methods articles in our review, study quality was evaluated by one person and two verifiers [5].

Conclusion

In order to answer the three research questions, data were analysed with the following goals: identifying patient engagement strategies and contextual factors that enable optimal patient involvement in the design, delivery, and evaluation of healthcare services; identifying patient engagement outcomes; and examining patient experiences of engagement. YB conducted both quantitative (frequency analysis) and qualitative analyses of the data. The outcomes, experiences, and contextual characteristics (i.e., barriers and facilitators) of the best patient engagement were identified by YB using theme analysis. This technique involves locating notable or recurrent themes in the literature that were pertinent to our study questions and using summary tables to compile the findings of several studies under thematic headings. In order to categorically characterise the tactics and contextual elements, a coding scheme was created.

Acknowledgement

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Conflict of Interest

None.

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