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Discharge Planning and Continuity of Care: A Mixed-method Evaluation of Patient and Caregiver Needs and Perspectives

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ABSTRACT

Background: Effective discharge planning is critical for ensuring continuity of care, yet significant implementation gaps persist in the Philippines from the perspective of primary recipients (patients and caregivers). ***Purpose*****:** This study aimed to evaluate their needs and experiences to identify key areas for improvement. ***Methods*****:** An explanatory-sequential mixed-method design was employed. First, a quantitative survey assessed the needs of 454 primary recipients in the Philippines. Subsequently, in-depth phenomenological interviews with 13 purposively selected participants provided deeper explanations for the quantitative findings. ***Results*****:** A universal 'Great Need' was identified across all discharge planning domains. The highest-ranked needs were (1) Medication Management, (2) Understanding the Treatment Plan, and (3) Emergency Preparedness. Qualitative themes explained these gaps, highlighting systemic Barriers to Effective Post-Discharge Management and a Superficial Understanding of the process. These experiences contrasted sharply with the ideal of an Empowered and Supported Recovery, revealing inconsistent practices. ***Conclusion:*** Discharge planning in the Philippines is fragmented, reflecting a systemic failure to prepare patients and caregivers for home transition, undermining continuity of care. ***Implications for Nursing***: Strengthening communication, standardizing patient-centered protocols, and actively engaging primary recipients from admission are essential to bridge the gap between policy and patient readiness, ensuring a safe recovery.

Keywords: Patient discharge, Patient needs, Caregivers, Mixed methods, Continuity of patient care, Philippines.

What does this paper add?

1. It quantifies the universal 'Great Need' for comprehensive support across all domains of discharge planning from the patient and caregiver perspectives.
2. It reveals how inconsistent communication and passive patient involvement lead to a superficial understanding of the discharge process, hindering post-discharge readiness.
3. It emphasizes the systemic failure to connect hospital-

based discharge with community care, advocating for a shift towards coordinated, personalized planning that empowers primary recipients.

Introduction

Discharge planning is a critical process in the continuum of care, facilitating a patient's transition from hospital to home. When executed effectively, it is widely recognized for reducing readmission risks, shortening hospital stays, and improving long-term health outcomes (Gonçalves-Bradley et al., 2022; Patel & Bechmann, 2023). Well-coordinated discharge planning is directly associated with lower mortality rates and enhanced patient satisfaction, primarily by mitigating the risks of unplanned readmissions and reducing out-of-pocket expenses (Yen et al., 2022).

However, despite established best practices, significant systemic failures in implementation persist, leading to fragmented care and poor health outcomes. In the Philippines, for instance, studies have documented both poor execution of discharge protocols and high rates of preventable 30-day readmissions linked directly to inadequate planning and communication breakdowns (Balane et al., 2023; Coyoca et al., 2024; Omonaiye et al., 2024). This is not a localized issue; international research indicated that up to a quarter of all hospital readmissions are preventable and often stem from poor communication, insufficient patient preparation, and a lack of self-management support (Kan et al., 2025; O'Mahony et al., 2023). These gaps often arise from inconsistent messaging, time constraints, and a failure to coordinate with community-based resources, leaving patients and their families to navigate a complex system alone (Sacks et al., 2020).

While these systemic shortcomings are well-documented, a critical knowledge gap persists in the literature regarding the perspectives of those most directly affected: the primary recipients of care—patients and their caregivers. Much of the existing research focuses on quantifiable, provider-centric metrics, like readmission rates and length of stay, often overlooking the qualitative, lived experiences of individuals managing the complex transition from hospital to home (Okoniewska et al., 2020). Caregivers, who are indispensable to a successful recovery, frequently report feeling unprepared and are often only passively included in the discharge process. This exclusion results in significant knowledge deficits, preventable complications, and avoidable readmissions (Lim et al., 2020; Topham et al., 2022). The process remains prescriptive, failing to empower patients with the self-management skills necessary for post-hospital care (Jaminola et al., 2022; Lopez et al., 2023).

This lack of focus on the primary recipients' journey represents a crucial blind spot in both research and practice. Without a deep, nuanced understanding of their specific needs, challenges, and satisfaction levels, interventions to improve discharge planning will remain centered on provider-defined processes rather than patient-centered solutions (Lewis, 2022). It is by exploring these firsthand experiences that we can identify the specific points of failure in communication, education, and support. Therefore, understanding and addressing this gap are essential for closing discontinuities in care, easing caregiver burden, and ultimately improving recovery outcomes. This study aims to bridge this gap by comprehensively evaluating the needs, satisfaction levels, and lived experiences of primary recipients, providing the evidence needed to build a more effective, supportive, and patient-centered discharge planning process.

Methods

Research Design

An explanatory-sequential mixed-method design was used. The study began with a quantitative survey to assess the discharge planning needs of primary recipients, followed by a qualitative phase involving in-depth interviews to explore the lived experiences of patients and caregivers.

Participants and Setting

Participants were recruited from three hospitals in Northern Luzon, Philippines. A total of 454 participants completed the quantitative survey, with a minimum sample size of 438 calculated using Epi Info (±5% margin of error, 95% confidence level). For the qualitative phase, 13 participants were selected from the initial survey pool using a purposive sampling strategy aimed at achieving maximum variation. This approach sought to capture a rich spectrum of experiences by intentionally recruiting individuals who represented different ends of the satisfaction and needs' spectrum identified in the survey data. Data saturation was achieved when no new themes emerged from subsequent interviews (Tight, 2023).

Inclusion Criteria

Eligible participants included individuals aged 18 years and above with a Mini-Mental State Examination (MMSE) score of 24 or higher. Caregivers were required to have substantial knowledge of the patients' hospitalization and attend follow-up appointments. All participants must have been discharged within the past three months and were receiving follow-up care.

Exclusion Criteria

Participants were excluded if they had cognitive impairments (MMSE score ≤ 23), or were experiencing acute medical issues, such as pain or surgical complications. Caregivers were excluded if they were not directly involved in the patients' daily care or if the patient had passed away.

Data Collections Instruments

A structured questionnaire was developed for the quantitative phase by adapting tools from relevant studies. The instrument was reviewed by four field experts for content validity, reliability, and clarity. It utilized a 4-point Likert scale to assess perceived needs across various discharge planning domains. The qualitative phase used a semi-structured interview guide to explore participants' phenomenological experiences.

Data Gathering Procedures

The study adhered to the 2022 Philippines Health Research Ethics Board (PHREB) guidelines, and ethical clearance was obtained from the participating hospitals. All data was collected between January 2025 and March 2025. Potential participants were identified from outpatient follow-up appointment lists and were approached by a research team member in a private area to explain the study and obtain informed consent. The questionnaire was interviewer-administered to ensure clarity and consistency. Interviews were conducted either in-person or virtually *via* Zoom. For virtual interviews, confidentiality was ensured through password-protected meetings, confirmation of a private setting, re-obtaining verbal consent, and storing all recordings in a secure, encrypted cloud-based drive.

Data Analysis and Management

All collected data will be securely managed to ensure confidentiality and integrity. Quantitative data from paper questionnaires will be digitized and entered into a secure database, which will be cleaned and checked for completeness. Qualitative audio recordings will be transcribed verbatim. All personal identifiers will be removed from both datasets and replaced with unique participant codes to ensure anonymity. The de-identified data will be stored in encrypted, password-protected files on a secure cloud drive, with access limited strictly to the core research team. All physical data will be stored in a locked cabinet and will be shredded after a five-year retention period, in line with institutional guidelines.

Quantitative survey data will be analyzed using Jamovi. Descriptive statistics, including frequencies, percentages, means, and standard deviations, will be calculated to summarize participant demographics and to address research objectives related to satisfaction levels and perceived needs. This analysis will provide a broad overview of trends and patterns across the participant sample.

The qualitative interview data will be analyzed using NVivo software to facilitate a rigorous thematic analysis guided by a Husserlian phenomenological approach. The process will involve several stages: (1) familiarization with the data through repeated reading of transcripts; (2) systematic line-by-line open coding to identify initial concepts; (3) grouping codes into potential themes and sub-themes; (4) reviewing and refining themes against the entire dataset to ensure that they are coherent and representative; and (5) defining and naming final themes. To ensure trustworthiness, rigor will be addressed through credibility (member checking), transferability (thick description of context), dependability (audit trail of the research process), and confirmability (researcher reflexivity).

Ethical Considerations

This study will be conducted in strict adherence to the ethical principles outlined in the 2022 Philippines Health Research Ethics Board (PHREB) National Ethical Guidelines for Research Involving Human Participants. Approval will be secured from the Saint Louis University Research Ethics Committee (SLU-REC) and the respective ethics committees of the participating hospitals prior to commencement of any research activities. A thorough informed consent process will be followed, providing all potential participants with a detailed information sheet (available in English, Tagalog, and Ilocano) and adequate time to ask questions before providing written consent. It will be emphasized that participation is entirely voluntary and that they can withdraw at any time without penalty or impact on their medical care. The privacy and confidentiality of all participants will be paramount; personal identifiers will be removed from all data and replaced with unique codes, while pseudonyms will be used in all publications. All digital data will be stored in encrypted, password-protected files, and physical data will be kept in a locked cabinet. To minimize harm, the risk of emotional discomfort during interviews will be managed by conducting them in a private setting and explicitly informing participants of their right to skip any question or stop at any point.

Results

The study gathered quantitative data from 454 primary recipients to evaluate their perceived needs related to Discharge Planning (DP). The findings revealed a notable contrast between these two areas. All domains of discharge planning were identified as areas of "Great Need," signaling a strong and consistent demand for more comprehensive support during the hospital-to-home transition.

The quantitative results revealed that primary recipients perceived a 'Great Need' across all discharge planning domains, with an overall mean score of 3.61. This indicates a strong and consistent demand for more comprehensive information, clearer communication, and robust support during the hospital-to-home transition. As shown in Table 1, Medication Management was identified as the area of highest need, while Self-care and Lifestyle, though still rated as a great need, was the lowest-ranked domain.

Table 1. Discharge planning perceived needs among primary recipients

Rank	Discharge Planning Domain	Overall Mean (SD)	Interpretation
1	Medication Management	3.67 (0.615)	Great Need
2	Understanding Diagnosis & Treatment Plan	3.64 (0.606)	Great Need
3	Emergency Preparedness	3.64 (0.597)	Great Need
4	Follow-up Care	3.62 (0.611)	Great Need
5	Communication and Coordination	3.58 (0.615)	Great Need
6	Self-care and Lifestyle	3.56 (0.653)	Great Need

Note: Interpretation is based on the scale: Great Need (3.26-4.00), Moderate Need (2.51-3.25), Low Need (1.76-2.50), and No Need (1.00-1.75).

All six domains of Discharge Planning were rated as a "Great Need," indicating a significant gap in post-hospitalization support. The most critical area of need identified was Medication Management (Mean=3.67), with specific items like knowing how to safely take medicine being a top priority. Other high-priority domains included Understanding the Diagnosis & Treatment Plan (Mean=3.64) and Emergency Preparedness (Mean=3.64), underscoring the demand for clear, actionable health information. Within the Communication and Coordination domain, the need to "receive clear talk with the doctor" was one of the highest-rated individual items in the entire survey. Notably, even the lowest-ranked domain, Self-care and Lifestyle (Mean=3.56), was still perceived as a 'Great Need,' which highlights the comprehensive and multi-faceted support that primary recipients feel is necessary for a safe transition.

The qualitative analysis of interviews with 13 primary recipients (identified by pseudonyms of Philippines national heroes) revealed three overarching themes related to their discharge planning experiences. As shown in Table 2, the prevalence of these themes varied significantly among informants, illustrating a wide spectrum of experiences, from feeling confident and well-prepared to feeling confused and unsupported. This reflects the inconsistency of current discharge practices.

Table 2. Thematic analysis of informant discharge experiences (%)

Informant	Empowered and Supported Recovery Experience (%)	Barriers to Effective Post-discharge Management and Continuity of Care (%)	Superficial Understanding and Engagement (%)
Aguinaldo	53.13%	21.09%	25.78%
Bonifacio	76.89%	20.17%	2.94%
Del Pilar	100%	-	-
Escoda	84.25%	-	15.75%
Felipe	90.74%	9.26%	-
Gomez	39.87%	60.13%	-
Jacinto	100%	-	-
Luna	71.98%	28.02%	-
Mabini	58.20%	32.82%	8.98%
Paterno	98.55%	-	1.45%
Quezon	15.94%	84.06%	-
Silang	76.10%	14.47%	9.43%
Zamora	38.73%	61.27%	-

Theme 1: Empowered and Supported Recovery Experience

This theme captures the positive outcomes that result from effective, patient-centered discharge planning. Participants who felt empowered described a sense of confidence and preparedness fostered by clear communication, active involvement in their care plan, and strong family support. This ideal experience was a result of several intersecting factors.

A strong sense of Confidence and Preparedness was a clear indicator of a successful discharge. Participants felt ready to manage their health at home, because the plan was tailored to their needs. As Jacinto shared, *"Um, it was just right. It matches what I need."* This readiness often translated into proactive behaviors. Luna, for instance, took concrete steps for her child's recovery: *"In terms of readiness, I'd say about 80%... We also stocked up on alcohol and other supplies, medicines—just in case—to prevent his condition from coming back."* For others, confidence came from a deep trust in the medical guidance provided. Mabini was resolute in her ability to follow instructions: *"Of course, I can manage myself. I really need to avoid whatever is prohibited... The doctor's instructions will still prevail... Won't you just keep going back to the hospital?"*.

This confidence was built upon the Comprehensibility of Discharge Instructions, driven by Effective Communication. Participants valued thorough, clear, and repeated explanations. Del Pilar recalled the personalized attention she received: *"In my case, there were three doctors… they each came to me one by one to explain what I needed to do—like how to treat my wound at home... just to make sure that my condition wouldn't get worse."* This sentiment was echoed by others who appreciated the opportunity to ask questions and receive clear answers. Bonifacio noted, *"Sometimes I do not understand, but they clear it right away to have a clear understanding."* The shift to written instructions was also a significant factor, as Felipe highlighted: *"Since it's written on paper, you can go back and read it anytime, unlike before when it was just verbal. Now it's easier to read and find when you need it."*

Family Involvement was frequently cited as an essential component of a supported recovery, acting as a crucial support system. Del Pilar noted how her family's medical background simplified her care: *"It was easy, because my mom and cousin are both nurses, so I just handed them the discharge instructions and they took care of me."* For others, family provided logistical and emotional support. Zamora's children were instrumental in navigating the administrative side of her discharge: *"Oh of course, my children. They always accompany me and they were the ones who processed my discharge papers."* The presence of family at home was also a source of comfort, as Jacinto simply stated, *"Yes. I have someone with me at home. So, it's home rest."*

Finally, participants who experienced an Active Involvement in Discharge Planning felt that their knowledge and preferences were valued, leading to a more collaborative and personalized plan. Jacinto shared a powerful example of shared decision-making that directly impacted her safety and care: *"I was given an antibiotic before for UTI, and I had an allergic reaction. So, when I informed them about it, we were able to look for an alternative antibiotic for me. So, they do listen whenever I say something."* This level of engagement ensured that the care plan was not only understood, but also appropriate for the individual.

Theme 2: Barriers to Effective Post-disscharge Management and Continuity of Care

This theme highlights the personal and systemic challenges that disrupt the transition from hospital to home. Participants described struggles with medication access, a lack of clear information, and a general unawareness of the discharge planning process itself, all of which created significant barriers to a smooth recovery.

Challenges in recovery and medication management were frequently reported, pointing to gaps in continuity of care. Gomez expressed frustration with the lack of follow-up from providers: *"After discharge, the doctor no longer cares. If you don't inform them, that's the problem—it takes so long to get information (shakes head)."* This feeling of abandonment was compounded by practical issues. Silang pointed to resource gaps that created financial and logistical hurdles: *"It's difficult here, because the medicines that I need to take every day aren't given for free, since only common medicines are always available."* For others, the challenges were more personal. Luna described the difficulty of administering medication to her resistant child: *"...giving the medicine was a challenge, because the child didn't want it. He didn't like the taste—it's like bitter melon"*. Zamora's experience of being readmitted just one month after discharge underscored the serious consequences of these barriers: *"After a month, I felt drained. So I told them that I cannot breathe. So, we returned to the hospital again"*.

A significant and foundational barrier was a fundamental Lack of Awareness on Discharge Instructions. This manifested as both a lack of sufficient information and a deeper lack of understanding of the process. Quezon shared her frustration with vague and incomplete guidance: *"That's the problem—they didn't explain. Sometimes I get annoyed (frowns). They didn't even say, 'This is for your stomach' or 'This is for your cancer.'"* This lack of information left her feeling unprepared: *"They don't tell you how to care for yourself."* For others, the entire concept of discharge planning was foreign, revealing a major gap in patient education. Mabini asked, *"Discharge, is this when I'll be leaving? The discharge plan?"* This confusion was echoed by Luna, who was unsure of her role and responsibilities in the process: *"What is it? (still confused). Is this on the side of the health care providers—like our doctors and nurses—or on our side as patients or guardians?"*

Theme 3: Superficial Understanding and Engagement on Discharge Planning

This theme reflects a surface-level engagement with the discharge process, where primary recipients viewed it as a simple, final administrative step rather than a structured process for ensuring continuity of care. This superficial understanding often led to a narrow focus on only the most basic instructions, leaving them unprepared for the complexities of home care.

Many participants demonstrated only a Basic Knowledge about Discharge Planning, equating it simply with the act of leaving the hospital. Bonifacio's interpretation was minimal: *"Ah it is what the doctors say."* Escoda's perception was similarly event-focused and logistical: *"For me, it means that it is done…After my wife has consumed her dextrose. We can already go home."* Paterno was even more direct and succinct, stating that discharge planning is when *"You're going home already."*

This limited understanding naturally resulted in a focus on Basic Discharge Instructions only, with little awareness of the broader elements of self-care, follow-up, or emergency preparedness. When asked about the instructions that they received, participants often recalled only information related to medication. Aguinaldo mentioned, *"Mostly just medicines [were given]."* Mabini's instructions were equally narrow and prescriptive: *"Dr. that I should get my medicine at the nearest health center or hospital."* This singular focus on medication indicates a significant gap in patient education and a failure on the part of the healthcare system to convey the holistic nature of post-discharge care, which includes monitoring symptoms, making lifestyle adjustments, and knowing when to seek help.

Discussion

This study reveals a critical paradox in the Philippines healthcare landscape: while an Empowered and Supported Recovery Experience is achievable, it is not the prevailing standard. The qualitative findings demonstrate that when discharge planning is communicative, patient-centered, and inclusive of family, primary recipients feel confident and prepared. However, this ideal is sharply contrasted by the quantitative data, which identifies a universal 'Great Need' across all discharge planning domains, confirming that systemic gaps are the more common reality. This juxtaposition of the possible *versus* the typical provides a nuanced interpretation of a system that is capable of excellence, but inconsistent in its delivery.

The universal 'Great Need' for support is not merely a statistic; it signifies a deep-seated feeling of vulnerability among patients and caregivers transitioning to home care. This study's results align with and expand upon existing literature that identifies major deficiencies in discharge processes. For instance, the high need for medication guidance (Mean=3.67) and clear communication (Mean=3.58) corroborates findings from O'Mahony et al. (2023) and Yao et al. (2020), which link such communication breakdowns directly to medication errors and adverse events. Our qualitative data further illuminates this, with the experiences of Silang (struggling with medication access) and Gomez (feeling abandoned by physicians post-discharge) providing a narrative face to these statistics. The rehospitalization of Zamora exemplifies the severe outcomes of a fragmented process, a finding consistent with studies that attribute high readmission rates to poor patient preparation (Balane et al., 2023; Tan & Rivera, 2025).

A core contribution of this study is the identification of a Superficial Understanding and Engagement with the discharge process as a foundational barrier. The qualitative theme revealed that many primary recipients perceive discharge not as a crucial phase of care, but as a perfunctory, administrative step before "going home." This surface-level perception is significant, because it explains *why* the 'Great Need' for education persists: information is not meaningfully absorbed when its purpose is not understood. While literature often calls for more comprehensive instructions (Okoniewska et al., 2020), our findings suggest that the problem is not just the content, but the context. This contributes a new perspective to the body of knowledge by suggesting that interventions must first reframe the purpose of discharge planning for patients, shifting it from a passive event to an active, collaborative phase of recovery.

Interpreted through the Donabedian model, these findings point to significant failures in the *process* of care, stemming from weaknesses in the *structure*. The inconsistency in patient experiences—ranging from the empowered (Del Pilar, Jacinto) to the unsupported (Gomez, Quezon)—suggests a lack of standardized, holistic discharge protocols. This structural deficit forces the process to be highly variable and dependent on individual providers. The resulting poor outcomes, manifested as a universal 'Great Need' for support, are a direct consequence. This confirms the model's assertion that a weak process, unsupported by a robust structure, cannot reliably produce positive health outcomes (Opele & Adepoju, 2024).

Ultimately, this study reinforces that discharge planning in the Philippines suffers from a significant gap between policy and practice. The process is often prescriptive and administrative rather than personalized and educational, a finding consistent with studies highlighting a lack of patient empowerment in the local context (Jaminola et al., 2022; Lopez et al., 2023). While some primary recipients benefit from exemplary care, the dominant experience is one of feeling unprepared and disconnected. This research contributes to the literature by demonstrating, through mixed methods, that improving discharge outcomes is not merely about providing more information, but also about fundamentally restructuring the process to be collaborative, educational, and patient-centered from the moment of admission.

Implications for Nursing

The results from this study carry significant implications for nursing practice, education, and administration, underscoring the pivotal role of nurses in bridging the identified gaps in the discharge planning process. As frontline providers, nurses are strategically positioned to transform discharge planning from a series of administrative tasks into a patient-centered, educational process. This involves ensuring that primary recipients receive clear, comprehensive, and understandable information about their treatment plans, medications, and follow-up care. The results advocate for initiating discharge planning upon admission, a practice supported by Lewis (2022), to allow for a thorough, unhurried, and multi-disciplinary approach that reduces readmission risk and enhances care continuity.

For nursing practice, this means championing patient and caregiver engagement, treating them as active partners in the care process. This can be achieved through techniques like teach-back to confirm understanding and by tailoring educational materials to the health literacy levels of the recipients. For nursing education, curricula should be enhanced to include robust training on patient-centered communication, health literacy assessment, and the principles of effective discharge planning that extend beyond the hospital walls. For nursing administration, the findings call for the development and implementation of standardized, yet flexible, discharge protocols that empower nurses with the time and resources to provide adequate patient education. Strengthening connections with community health resources is also crucial, and nurses can act as the key coordinators in this transition, ensuring a seamless handover and sustained recovery for patients (Sacks et al., 2020). By integrating these strategies across clinical practice, education, and policy, nursing can lead the charge in ensuring safer, more effective, and more human care transitions.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, the research was geographically confined to urban settings in Baguio City and La Trinidad, Benguet, Philippines, which may limit the generalizability of the results to rural or remote communities where healthcare access and resources differ significantly. Second, the study excluded participants with private health insurance, focusing primarily on those covered by PhilHealth, which narrows the understanding of healthcare experiences across different insurance models.

Methodologically, the use of convenience sampling, while being practical, introduces a potential for selection bias, as it may not capture the experiences of those who do not or cannot attend follow-up appointments. Furthermore, while the explanatory-sequential mixed-method design provided rich, integrated data, the qualitative sample was limited to 13 participants. Although data saturation was reached, a larger sample might have revealed a greater diversity of experiences. Finally, the study did not analyze data across specific hospital departments or providers, making it difficult to determine whether identified issues, such as poor communication, are systemic or isolated to particular units or individuals.

Conclusion

This study concludes that a significant gap exists between the perceived needs of primary recipients and the current state of discharge planning in the Philippines healthcare system. While an empowered and patient-centered recovery is possible, it is not consistently achieved. The universal identification of all discharge planning domains as a 'Great Need' underscores a systemic failure to adequately prepare patients and caregivers for the transition from hospital to home. Both positive and negative experiences highlighted the critical necessity for clearer, more structured, and collaborative discharge planning. The findings reveal that superficial engagement, inconsistent communication, and a lack of patient empowerment are key barriers that must be addressed to promote continuity of care and improve post-hospitalization health outcomes.

Recommendations

Based on the results, future practice should focus on developing and implementing a standardized, yet flexible, patient-centered discharge protocol that is initiated upon admission and includes a robust monitoring system for both short- and long-term outcomes. This process must incorporate demographic and social determinants of health to better understand their impact on patient needs. To support this, nursing education and professional training should be enhanced to focus on patient-centered communication and health literacy assessment. Future research should expand on these findings by comparing discharge experiences in urban *versus* rural settings to address geographical disparities and by investigating the experiences of primary recipients with private health insurance to provide a more comprehensive view of the healthcare landscape.

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Conflict of Interests

The authors affirm that no conflict of interests is associated with this research. The study was undertaken independently, and all components—including the design, data collection, analysis, and interpretation—were conducted without any external influence or interference.

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