An Assessment of Hospice Patient Experience with Cancer Care Services in the United States Hospitals: A Mixed-Method Study

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Abstract

This mixed methods research (MMR) addressed management's failure to give high-quality hospice care in healthcare facilities within the United States. Failure to provide high-quality care leads to issues with quality control and customer satisfaction. The researcher used an MMR design to perform a systematic survey of 96 participants in select U.S.-based hospice services management facilities. The medical records from the Research Institution organization were used to choose the participants. The total population was 1,300 from which 96 participants were randomly chosen. This study's first phase included surveying participants utilizing questions from a Likert scale that yielded quantitative responses. The second phase applied a methodical procedure employing open-ended questions to pull thoughtful answers from the participants. Doctors, nurses, hospice leadership, patients with cancer in hospice care (inpatient and outpatient) and veterans were interviewed. Doctors, nurses, leadership, patients, and veterans played a role in this study that focused on Maslow's leadership management theory. The significant issue was addressed by interviewing 25 veterans, 11 leadership management positions (doctors, nurses, leadership), and 60 cancer patient participants at their end of life. Several themes were discovered, which permitted the researcher to suggest potential implementation strategies to be adopted by leadership management in hospice care. The over-arching theme examined in Section 2 and Section 3 of this study formed a basis for further research on the existing literature gaps and for leadership management to use this study to implement best practice in hospice care organizations. Addressing these issues in hospice care may require using ideas mentioned in the recommendations of Section 3. Recommendations concerned implementing strategies to improve patient quality of care, to address staff burnout and employee well-being, to increase motivation and improve communication, and to consider the patient's financial well-being before and after their end of life. The research findings help shed light on the quality of care, leadership involvement, and patient-centered issues for individuals with cancer and their families in the last days of life.

Keywords: Burnout, Communication, Financial, End of Life, Leadership, Management, Motivation, and Quality of Life

An Assessment of Hospice Patients' Experience from Cancer Care Services in the United States Hospitals: A Mixed-Method Study

By

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Approvals

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Dedication

In memory of Queen Victoria Obasun, a promise was made to her before her passing in finishing a third doctoral level. She was diagnosed with stage four cancer while completing my 2nd doctorate in 2016; she passed away on May 21, 2018, from pancreatic cancer in a Hospice facility. As the elder son, she relied on me, especially telling me things. She wanted to die at home, but other factors led to her death at a facility. The dissertation is dedicated to her. On behalf of her memory to close the gaps and make health management a better process at all hospice locations.

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Section 1: Foundation of the Study

Hospice care management requires beneficial factors in patient satisfaction and the fulfillment of cancer patients' wishes at the end of their lives. Researchers have shown that hospital care management can solve many of the problems experienced by cancer patients (Jacobs & Shulman, 2017). Patients who need advanced care are often in pain and distress and experience dyspnea at the end of life. When close to their deaths, the patients often make use of intensive hospital-hospice services. This ensures that terminally ill patients receive relief from their suffering while receiving the love of their family members. However, various external factors affect the outcomes of hospice care, especially the length of stay (Odejide & Steensma, 2020). This study focused on understanding the quality of hospice care and sought to determine whether patients’ experiences can be improved through better management in hospitals in the United States. The evaluation was accomplished by analyzing existing literature and interviewing hospice care professionals and their patients. In addition, this research incorporated interviews with families, patients, staff, other stakeholders who had experience with hospice care, and family members who lost relatives to cancer between 2019 and 2023. The interview questions targeted hospice patients and management by the facilities, quality of life, and the fulfillment of the patient's end-of-life wishes. The researcher examined a cohort of 96 participants. Sixty of the participants were cancer patients: half of the patients were inpatient (30), and the other half (30) were in the intervention outpatient group receiving home hospice care. The remaining participants consisted of 25 veterans, and 11 participants in leadership management positions.

According to several researchers' findings, some patients receiving hospice care at home experienced better end-of-life treatment than those who did not accept hospice care at home and opted for an in-house hospital facility (Chan et al., 2020; Oriani et al., 2021; Osagiede et al., 2018). For example, some patients receiving hospice care were given medication to manage their pain symptoms, while some patients in other control-centered groups did not receive any medication, sometimes due to the quality of care and insufficient staffing. In addition, the families of the patients who receive in-home hospice care have reported that their pain management regimes are well-coordinated with their symptoms compared to the inpatient care centers. This is a valuable indicator of the quality of care and significantly boosts patient satisfaction.

As healthcare regulations develop, the management of the facilities demands assurance of high-quality hospice care and customer satisfaction within hospice care to ensure suitable patient outcomes (Perumalswami et al., 2020; Yabroff et al., 2019). Advancements have been made in the early detection and treatment of a few cancer types in the last century (Bergerød et al., 2020). However, current statistics reveal that almost half of the patients diagnosed with cancer typically die from the disease after one to four years (Sey & Hunter 2020). In 2020, there were 1,806,590 new cancer cases, and 606,520 cancer deaths were forecasted to transpire in the United States (Siegel et al., 2020). However, studies reveal that early detection of cancerous growth can improve patients' quality of life because interventions can be offered in real-time to prevent the disease from advancing (Miller, 2020).

Background of the Problem

The burden of cancer in the U.S. necessitates an effective hospice system and meticulous quality control for management (El-Jawahri et al., 2021). An effective management system can resolve problems related to cancer care, improve patient quality care, and address patients' needs. Assessing the nature of hospice management in U.S. hospitals helps to identify ways to strengthen hospice care to enhance cancer patients' experiences (Jacobs & Shulman, 2017; Osagiede et al., 2018). However, acknowledging the organizational demands and difficulties confronted by nurses, more organizations have concentrated on matters relating to management’s failure to provide high-quality hospice care in healthcare facilities. This has resulted in quality control issues and customer dissatisfaction within the hospice center, sometimes creating dynamics such as burnout and compassion fatigue (Abu-Odah et al., 2020).

Quality control issues and failures sometimes lead to employee burnout in healthcare management and may result in death for patients. This matter requires increased attention in research and organizational development worldwide. In the U.S., compassion fatigue and burnout have been concepts defined by scholars as work-related occupational stress. Considering the cost of this issue, healthcare organizations need to implement practices like relational work systems to ensure this concept is competently addressed across all organizational boundaries. As hospice agencies contend with widespread management issues, factors leading to burnout include emotional exhaustion and longer working hours. Burnout has a highly detrimental effect on both staff and patients and harms the quality of care. A greater focus on the problems associated with compassion burnout and worker burnout could decrease the inherent losses likely to be experienced by the workers and employers (Dawson et al., 2021). There can be hazardous outcomes of compassion fatigue and burnout which may result in decreased quality of hospice care and facilities and management may be at danger of negligence lawsuits, high employee turnover and prolonged sick leave, resulting in increased worker's compensation cases (Osagiede et al., 2018). Workers may also develop stress-related medical conditions such as high blood pressure or psychological problems such as anxiety-related disorders, affecting work quality and leading to challenges for effective hospice management (Steensma et al., 2017).

This research project investigated numerous factors within the failure of the management process in the hospice industry. The data shows that multiple public health advisory organizations have begun to recognize the importance of early prevention in quality associated issues (Jacobs & Shulman, 2017; Osagiede et al., 2018). An example of this is ensuring that inpatients experiencing severe pain and acute symptoms are treated in a designated hospice facility such as a Medicare-certified hospital, hospice inpatient facility, or nursing facility. Furthermore, it is essential that the 24-hour nursing staff and hospice management execute a highly personal level of quality patient care.

Problem Statement

The general problem to be addressed in this study was management's failure to provide high-quality hospice care in healthcare facilities, resulting in quality control issues and customer dissatisfaction within hospice centers (Jacobs & Shulman, 2017; Osagiede et al., 2018; Pesut et al., 2020). Individuals with financial problems face an increased risk of not having treatment and care for cancer due to the lack of health insurance and high costs associated with caring for cancer patients (Tarazi et al., 2016). Research by Jaroff et al. (2019) documented the disparities in cancer care due to patients' economic status, while the American Society of Clinical Oncology (2017) showed persistent high mortality rates. Frick et al. (2019) showed how continuous support and care are essential in improving the quality of life of cancer patients. The specific problem to be addressed was management's prospective failure to provide high-quality cancer care in healthcare facilities in the United States, resulting in potential quality control issues and customer dissatisfaction among cancer patients (Marzal-Alfaro et al., 2020; Tandon et al., 2020).

The complexity of cancer patient care during the end-of-life care system is undeniable due to the massive levels of turmoil, anxiety, and worries of failure associated with the cancer process (Cordella & Poiani, 2021). There is a need to focus on the lack of aggressive management of hospice care to provide high-quality hospice care. This lack of aggressive management often results in low-quality patient care and identifying this as a quality priority may help improve healthcare (Kim et al., 2019). Hospice systems must focus on achieving the best possible quality of care and address failures to provide high-quality cancer care in healthcare facilities (Marzal-Alfaro et al., 2020; Tandon et al., 2020).

Purpose Statement

The purpose of this mixed-method study was to address management's failure to provide high-quality cancer care in hospice healthcare facilities in the United States, resulting in quality control issues and customer dissatisfaction among cancer patients (Marzal-Alfaro et al., 2020; Tandon et al., 2020). The research attempted to identify the driving determinants in management designs and causation of burnout and included a literature review of leadership theory. Hospital custom often concentrates on the present; by nature, general physicians train to treat patients who can be cured rather than those hospitalized for a terminal disease (Kleinman, 2017). In healthcare, ethical attentiveness governs all decision-making in a field where people's lives are at stake (Walker & Mcmillan, 2021). The intricate reasons for the failure of quality of care in the hospice industry were considered through an in-depth study of the employees, patients, and stakeholders. This is crucial for nurses and physicians who assist patients needing constant care. It is equally necessary for end-of-life care that incorporates considerations for patient requirements on multiple levels (Hall, 2020). According to Best (2020), quality care that addresses the patient's desires results in satisfaction and increases the quality of the patient's life. The research questions in this project filled a knowledge gap and added to the existing body of literature through discussions concerning quality of care, the factors that impact the preparation of the quality of care in the hospice environment, and quality improvement.

Research Questions

The literature showed that there is still much to be done in promoting patient experience and satisfaction with hospice care. This study sought to address the following questions concerning the quality of hospice care management within the United States. Tashakkori and Creswell (2007) assert that they typically do not see selective questions or hypotheses tailored to mixed-methods research. Nevertheless, this study began with using a quantitative question. Applying such methods shaped the strategies and the study's overall design. Mixed-methods research does not solely rely on quantitative or qualitative research; rather a mixture provides the most beneficial knowledge for the research questions and hypotheses. Overall, it was essential to consider the varieties of questions that should be presented, and to consider when and what information was most appropriate to communicate the nature and purpose of the study (Creswell & Plano Clark, 2007; Tashakkori & Creswell, 2007).

Quantitative Question

RQ1. What are the key management issues affecting the quality of hospice care for cancer patients?

Qualitative Question

RQ2. How does each management issue contribute to patient outcomes?

RQ3. How does the assessment of patient need in cancer care contribute to quality control issues and patient satisfaction?

Quantitative Question

RQ4. What is the relationship between care needs for different types of cancer patients and patient satisfaction?

RQ5. What improvement interventions should U.S. hospitals adopt for the efficient management of cancer patients?

RQ6. What evidence-based care interventions have been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients?

RQ7. To what extent, if any, is there a relationship linking aggressive symptom management and intense hospice care to provide high-quality hospice care results in low-quality care and management issues?

Discussion of Research Questions

Quantitative Question

RQ1. What are the key management issues affecting the quality of hospice care for cancer patients?

Management issues such as staffing and rising healthcare costs significantly contribute to hospice patient experience in cancer care services in the United States (Marzal-Alfaro et al., 2020; Tandon et al., 2020). Identifying management issues that affect the quality of hospice care for cancer patients provided an evidence-based framework for assessing hospice patient experience and general patient outcomes. The purpose of integrating this research question into the study was to narrow down the scope of research to specific management issues affecting hospice experience for cancer patients. Carmont et al. (2018) identified characteristics that revealed management issues affecting patient care and hospice experiences. This author's research played a critical role in increasing the expertise and knowledge of health and social services associated with cancer hospice care.

Qualitative Question

RQ2. How does each management issue contribute to patient outcomes?

Patient-centered cancer care services require a dedicated focus on the patients' physical and emotional well-being to improve their quality of life and prolong their lifespan. Improvement interventions, such as reducing the nurse-to-patient ratio, lower hospital mortality rates. Hospice care for cancer patients entails specialized treatment therapies, which significantly contribute to increased care costs. This research question aimed to improve the formulation of issue-specific solutions to cancer patients' key challenges. Gallan et al. (2019) asserted that patient-centered cancer care services should focus on the patients' physical treatment process and transform community well-being through the patient’s quality of care.

RQ3. How does the assessment of patient need in cancer care contribute to quality control issues and patient satisfaction?

Investigating the inadequate assessment of patient needs in cancer care is essential in identifying quality control and patient satisfaction issues in hospice management. It was a reasonable question to integrate into the study as it aligned with the overall objective of the research in assessing the hospice patient experience within the United States. This question supported the general problem of quality control issues that contribute to low patient satisfaction in cancer care. Kreuter et al. (2017) have posited that improving quality of life and management should be prioritized and implemented with multidisciplinary participation from clinicians, specialist nurses, psychologists, and social workers.

Quantitative Question

RQ4. What is the relationship between care needs for different types of cancer patients and patient satisfaction?

Different types of cancer have varying effects on patients depending on the body organs affected. For instance, throat cancer may affect the patient's ability to ingest food normally, while prostate cancer may affect mobility. These differences result in various patient care needs and specific quality control indicators. This question supported the existence of the general care quality issues in the U.S. and was important to integrate into this study as a means of formulating patient-centered improvement interventions. Osagiede et al. (2018) discussed these specific processes among patients with various cancers by employing statistics from the National Cancer Data Base which documents the control issue among different diseases.

RQ5. What improvement interventions should U.S. hospitals adopt for the efficient management of cancer patients?

This research question aimed to identify management issues in the hospice patient experience at a cancer care facility in the United States. The goal of investigating this issue was to reduce quality control issues and improve patient outcomes. This research question formed a solid basis for aligning specific management issues with their relevant interventions. It furthermore laid the groundwork for confirming existing management issues and proposing improvement interventions to manage treatment outcomes in the United States. Clayton et al. (2019) asserted that the hospice identification in management employs the subordinate technique of discussion topics associated with self-perception and communication effectiveness.

RQ6. What evidence-based care interventions have been implemented in the U.S. healthcare system to improve cancer patients’ treatment outcomes and satisfaction?

The practical formulation of relevant care interventions to address quality control and patient satisfaction issues in the U.S. requires alignment with the existing solution frameworks already implemented. This question supported the existence of quality issues and acknowledged the efforts that have been put in place to improve patient satisfaction. This question supported the seamless integration of the new quality improvements into the U.S. health care system to achieve optimal outcomes. The problem statement's intended result was to explore the overall reduction in quality control issues and patient satisfaction outcomes. Brown et al. (2019) showed that quality of care and management processes are related to quality control issues and improved patient satisfaction outcomes. The authors have termed this performance feedback intervention theory (CP-FIT): an innovative theory for designing, implementing, and assessing feedback in healthcare based on a systematic review.

RQ7. To what extent, if any, is there a relationship linking aggressive symptom management and intense hospice care in providing high-quality hospice care results in low-quality care and management issues?

This research question focused on the hospice care management process within healthcare facilities that fail to provide high quality care and patient satisfaction. This question concentrated on the relationship between known factors and testable variables based on the statistical significance. Overall, the research design used mixed-methods for the study and focused on preliminary steps in the research process. Alavi et al. (2018) demonstrated that a mixed-method design has the potential to improve the quality and experience in practical research, in part because it allows for a more precise delineation of the research problem.

Discussion How Taken Together, Research Questions

The research questions showed the study design and the justification for using mixed-methods to research hospice patient experience with cancer care services in the United States. It also allowed for merging idiographic knowledge with nomothetic data from different sources (Schoonenboom & Johnson, 2017). The study design composed a solid foundation for aligning specific management issues with their relevant interventions. All the questions confirmed the existing management issues and examined the need to formulate improvement interventions to manage treatment outcomes in the United States.

This study's scope was guided by pertinent research questions focused on quality control issues that influence patient satisfaction in cancer care services. The study process explained the relationship between each research question and patient outcomes. It offered valuable insights into the formulation of relevant improvement interventions to efficiently manage cancer patients in the United States. Each research question and sub-question was formulated to assess quality control and patient satisfaction issues from cancer care services in U.S. hospitals. A discussion of how each research question supported management issues and the potential consequences based on the problem statement provided a solid justification for their integration into the study.

Hypotheses

The primary hypothesis corresponded to the fundamental examination question and investigated the statistically significant relationships that show management's failure to provide high-quality hospice care, which results in issues with quality control and customer satisfaction (Pesut et al., 2020). The null hypotheses ($H1_0$) including alternate hypothesis (H1a) are as follows: questions 1,4,5,6 and 7 are quantifiable, and questions 2 and 3 are qualitative.

Quantitative Question

RQ1. What are the key management issues affecting the quality of hospice care for cancer patients?

$H1_0$: There are no statistically significant key management issues affecting the quality of hospice care for cancer patients.

H1a: There is a statistically significant key management issue affecting the quality of hospice care for cancer patients.

Quantitative Question for Question 4 to 7

RQ4. What is the relationship between care needs for different types of cancer patients and patient satisfaction?

$H4_0$: There is no statistically significant relationship between care needs for different types of cancer patients and patient satisfaction.

H4a: There is a statistically significant relationship between care needs for different types of cancer patients and patient satisfaction.

RQ5. What improvement interventions should U.S. hospitals adopt for the efficient management of cancer patients?

$H5_0$: There is no statistically improved interventions should U.S. hospitals adopt for the efficient management of cancer patients?

H5a: There is a statistically significant improvement intervention for the efficient management of cancer patients?

RQ6. What evidence-based care interventions have been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients

$H6_0$: There is no statistically significant evidence-based care interventions that has been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients.

$H6_a$: There is a statistically significant evidence-based care intervention that has been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients.

RQ7. To what extent, if any, is there a relationship linking aggressive symptom management and intense hospice care to provide high-quality hospice care results in low-quality care and management issues?

$H7_0$: There is no statistically significant relationship linking aggressive symptom management and intense hospice care to providing high-quality hospice care results in low-quality care.

$H7_a$: There is a statistically significant relationship linking aggressive symptom management and intense hospice care to providing high-quality hospice care results in low-quality care.

Discussion of Hypotheses for Quantitative Questions

The hypothesis for RQ1, related to the primary research question and examined statistically significant relationships between the key management issues affecting the quality of hospice care for cancer patients. The shift concerning the provision of quality cancer treatments has shown the growing significance of patient experience. Improving patient experience has an intrinsic value to patients and is thus a vital outcome in its own right. However, it is critical to link the data to crucial clinical processes and patient outcomes. Simões (2020) showed documentation and coded discussions between physicians and 172 newly detected breast cancer patients. This remarkable research found that physicians concentrate approximately 88% of their time on practicing medicine on biomedical matters, rather than on patients' time in the hospital or fulfilling the process or on the communication process (Simões, 2020). Issues related to quality care are critical to discussions about hospice care, and should determine guidelines concerning clinical decision-making, expansion in medical technologies, and policy changes and legislation on cancer matters.

The hypothesis for RQ4 addressed the relationship between care needs for different types of cancer patients and patient satisfaction. Sandsdalen et al. (2016) interprets patients' perception of quality care within several care facilities in two ways, namely the ability to satisfy patients' predilections for care and zones of perfection. Concerning the Patient Reality (PR) scale, significant alterations were recognized in patients' awareness of care; some received classes based on the study and backgrounds. The background breaks down into two scopes, Socio-Cultural (SC) and Identity-Orientation (ID). For the (SC) facet, patients in hospice inpatient management and hospice daycare recorded higher than the patients under home-based care (Sandsdalen et al., 2016). Patient management in hospice inpatient care shows higher care received for the (ID) facet than patients in hospice entities in nursing institutions. No essential changes were noted with regard to the patient's awareness of care received and the independent variable, such as education level and diagnosis (see Figure 1).

The hypothesis for RQ5, addressed statistical significance based on evidence-based care interventions implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients. Zimmerman et al. (2016) argued that patients and care providers in the intervention and control sets had an amazingly reliable explanation of their primary perception of palliative care. Thematically, the concept of hospice care was identical to death and care delivered in the patient's last days (Zimmerman et al., 2016). From this perspective, hospice care is a passive form of care when nothing can be done and there is no hope for the patient’s survival. Patients with advanced cancer discredited hospice care, linking it with death and care services that are only offered at the end of life. This provokes anxiety and avoidance for some patients, and they sometimes deliberately avoid hospice care because they associate these services with death. Some also believe that cancer is incurable and show various emotions towards the reality of dying (Zimmerman et al., 2016).

The hypothesis for RQ6, followed the fifth hypothesis by relating scientific observations to the statistics concerning the evidence-based care interventions that are implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients. This hypothesis showed the cost-related access problems that many patients have experienced in recent years (Zimmerman et al., 2016).

The final hypothesis for RQ7 considered the statistically significant relationship linking aggressive symptom management and intense hospice care to providing high-quality hospice care results in low-quality care and management issues. This hypothesis emphasized the participants by stressing the need to restructure and equip healthcare professionals to increase awareness about hospice care.

Surveys conducted by Mollica et al. (2017) and Chen et al. (2020) showed that nearly 24% of adult patients had previous experience with cancer, while 86% remained confident in the process but were unaware that the shift towards providing high-value cancer care has placed increasing importance on patient experiences. Participants proposed the rebranding and renaming of hospice care as a strategy to address the discordance amid early palliative care received by patients, and to minimize the tenacious association of the word in question with the end-of-life care (Mollica et al., 2017). Comparable outcomes have been documented in other empirical studies where accomplices chose supportive care compared to palliative care, despite explaining the services offered.

In a study by Collet (2019), participants (118) reported a positive lung cancer care coordination experience, but this was with increased communication and navigation subscales scores. However, there is a need for effective strategies to aid patients residing in rural places and no healthcare system experience (Chen et al., 2020). One out of five patients reported confusion about the roles and duties of various care providers involved in their hospice care. Moreover, the concerned care providers were partially informed about cancer progress history (Collet, 2019). Nearly 19% of the participants reported difficulties satisfying their financial obligations concerning their medical expenses, such as Medicare and private health aid claims. Almost 15% of the participants reported receiving insufficient information concerning monetary entitlement to Medicare and private health capital claims (Chen et al., 2020). Moreover, nearly 15% of the participants did not understand how to access treatment during business hours, while others experienced difficulties making an appointment with their physicians.

Discussion of Qualitative Research Questions

Question 2 presented a consonant-order and answered the research question that explored the statistically significant issues contributing to patient outcomes. This question was also a subset analysis of Question 1. Shekhar et al. (2019) addressed information on provider-patient communication. Factors such as friendliness, courtesy, empathy, and encouragement are communication traits that reliably increase patient satisfaction. The authors stress the need for care providers to express love, compassion, and respect, which can encourage confidence among cancer patients to explain their feelings and be in a position to understand their conditions and everyday reality. Expressing empathy will make patients feel loved and appreciated. This can also free patients to make rational decisions on how they would handle other matters.

Similarly, Parikh-Patel et al. (2017) asserted that inadequate provider communication happens when care providers fail to discuss essential topics such as symptom management, practical care necessities, spiritual concerns, and proxy documentation. Approximately 52% of the participants (respondents) reported insufficient provider communication. About 90% of stage III to IV cancer patients reported receiving inadequate to no information concerning cancer (Simões, 2020).

RQ3 corresponded to the study question that explored the statistically significant correlation between improvement interventions in the United States hospitals and the adoption of efficient management methods for cancer patients. Chen et al. (2020) indicated there is inadequate systematic data concerning the quality of healthcare services, professional healthcare providers, and other providers in managing critically ill patients. These inadequacies are experienced mainly in outpatient settings. Consequently, healthcare stakeholders and patients (clients) lack actionable methods to guide healthcare development efforts that are underpinned by The National Quality Forum (NQF), The Centers for Medicare and Medicaid Services (CMS), and NCP Guidelines (NCP) (Chen et al., 2020). In addition, comprehensive hospice care services are underrepresented in the CMS, and the Quality Payment Program (QPP), with recent measures addressing only a few cancer patients and limiting them from accessing cancer management. Moreover, the quality of hospice care assessments incorporating patient references is conspicuously absent, despite the patient-centered nature of hospice care. Patient-centered approaches are a vital complement to clinical data information (Bainbridge & Seow, 2018). It is therefore essential to address the risk of prejudice when care providers are requested to measure efficiency. An institute that shows reporting data on their healthcare process can impact observance of the quality-of-care process overall, helping patients circumvent the threat of the validity of quality of the healthcare measures. Cancer patients often feel silenced and misunderstood. Systematic monitoring, reporting, and responding to patient experiences are thus critical in creating and sustaining an enabling medical environment that improves care for patients with terminal illnesses such as cancer.

The Nature of the Study

The research paradigm and design played critical roles in guiding the formulation of research questions and outlines. A detailed exposition of the research paradigm specified various sections and subsections to answer the research question comprehensively. The plan was discussed in the research design and explained the rationale for utilizing qualitative and quantitative methods to answer the research questions. The research paradigm enabled the investigator to apply multiple concurrent strategies at different research process phases (Dawadi et al., 2021). The research paradigm also focused on the positivism objective to discover better processes for hospice patient management in seeking truth and discovery. The research utilized a mixed-method form with a qualitative and quantitative approach, specifically a convergent parallel design.

Discussion of Research Paradigm

The research paradigm was a positivism objective with a convergent parallel design to discover better processes for hospice patient management in seeking truth and discovery. These discoveries guided the study and scope of investigations to formulate the research question and timelines. The study was conducted with a mixed-method design with a qualitative and quantitative method, specifically a convergent parallel design. The research paradigm offered essential insights into developing an outline for identifying various treatment aspects of hospice care for cancer patients addressed in the research (Tashakkori et al., 1998). Tashakkori et al. (1998) followed a similarly mixed methodology combining qualitative and quantitative approaches. The study covered the critical quality control issues and the potential solutions to improving hospice care for cancer patients in the United States.

Different research paradigms, for example, positivism, post-positivism, constructivism, and pragmatism, have been employed by various researchers (Dawadi et al., 2021). This process creates intrinsic variations for the study process, and each might have been utilized as the basis of this research. One focus of employing a positivist research paradigm is to aim the study to potentially foresee the future. Positivism allows the researcher to study and identify the influence of specific variables, which may lead to an appropriate conclusion (Alharahsheh & Pius, 2020).

Post-positivism is also known as methodological pluralism (Gamlen & McIntyre,2018). According to Krauss (2005), the paradigm process within any research selection determines the research methodology. The post-positivist paradigm emerged from the positivist paradigm, all so needed within the operation of this study. In turn, it might help blend the interpretivism of the human interest into an investigation and the existing built form of human constructs and activities (Van Der Walt, 2020).

The constructivist paradigm uses the views of the individuals to try to explain the phenomenon and establish bases. An essential contribution of constructivism guided research is most likely to rely on qualitative, and since this was a mixed-method design study, constructivism could not solely be employed in mixed-method research (Van Der Walt, 2020).

The pragmatic study involves utilizing the most suitable method for the nature of research to be convoyed (Zolin et al., 2020). In a way, the study was a practical design for this paradigm. Pragmatics recognize that there are various methods of interpreting the world and engagement of research (Zolin et al., 2020). Yet, pragmatism did not suit this current research because hospice is a system-focused industry that must reach a better quality of services in the healthcare and hospice industries.

Discussion of Design

The research design involved an intense examination of data that correlated to several variables. An intensive study about an organization's hospice quality of care allowed generalization concerning similarly diverse units. The research approach narrowed down broad and complex topics of organizational status into more manageable research questions. The rationale for using mixed methods in researching hospice patient experience in cancer care services in the United States allowed for the iterative merging of idiographic knowledge with nomothetic knowledge from diverse sources (Schoonenboom & Johnson, 2017). The data produced from a mixed design supported the research questions from both a practical and theoretical perspective. Gaining access to a rich data source gave the process a convergent parallel design (Delaney et al., 2017). This process also provided a systematic approach: it centered on quantitative results and selected the best participants to fit in a qualitative study, which led to the Institutional Review Board (IRB) process and approval (Watkins & Gioia, 2015).

Fixed Design Using Quantitative Method

As stated by Wright et al. (2016), quantitative methods commonly assess theory and encompass deductive logic, beginning with general arguments of theories and concepts that produce data points. Quantitative research aims to provide objectivity and lessen the researcher's influence on data collection (Wright et al., 2016). The quantitative analysis supports randomly generated sizable samples, specifically if the research is intended to be generalizable to other populations. Thus, solely using the quantitative approach for this study would not provide the researcher with an in-depth understanding of hospice patients' experiences with cancer care services.

Kan and Gero (2017) posited that fixed designs are a component of research design. Following the research approach, the researcher administers the research and analysis, utilizing quantitative means as defined in the research procedure. These artifacts usually meet the need or achieve the goal of the study design built on the knowledge base by designing and building the research design. The fixed method research design will often neglect the population values, truth, and understanding of the historical importance of the literature review. However, the difficulty with a fixed design is that it may cut the research process short. Therefore, another way to share configuration protocols is by design moves and employing the mixed method (Creswell, 2016).

Flexible Design Using Qualitative Method

Qualitative methods are employed to answer questions about experience, meaning, and perspective from the participant's perspective (Hammarberg et al., 2016). This information is typically not amenable to counting or measuring. Qualitative research may be comprised of small-group discussions for exploring beliefs, attitudes, and concepts of behavior; semi-structured interviews to inquire about views on a specific topic; or in-depth interviews to apprehend an experience or event from a personal perspective (Hammarberg et al., 2016). However, using only a qualitative approach would not provide this researcher with necessary data points to elucidate the numerical data related to quality control issues and other numerical variables.

Creswell and Poth (2018) posited that flexible design is a conventional part of a study’s design. Kan and Gero (2017) also asserted that a flexible method is needed for employing the qualitative process. In some cases, the approach leaves respondents more curious, open-minded, and empathetic. Applying the qualitative approach requires flexibility to listen and develop arguments while allowing for the continuous integration of current statistical data of the quantitative portion (Kan & Gero 2017).

Mixed-Method Design Using Quantitative and Qualitative Method

The research approach is fundamental, and the design is more relevant to the researcher's clear research focus and strategy (Creswell, 2016). The goal is to discover new ideas and their associations, and many researchers argue these focal points, expectations, outcomes, and challenges (Creswell et al., 2018). Consequently, it was essential to use a mixed-method format in this research, combining both concepts in equal amounts (Creswell, 2016). Regarding mixed-method research design, Crowe et al. (2017) asserted that, in some arrangements, quantitative methods aid in accommodating data found through the fundamental qualitative techniques. This includes, for example, the use of descriptive statistics on demographics or other related numerical information. The correlation of these factors with the organization's hospice quality care required that the study employ a mixed-method research design.

Johnson et al. (2019) asserted that mixed-methods research incorporates various causal concepts, notions, approaches, and techniques. These researchers posit that mixed designs can solve a complex problem in ways that qualitative or quantitative methods cannot do alone. Guetterman et al. (2019) similarly discussed how a mixed-methods approach collects both numerical and textual data. Researchers must be familiar with the strengths and weaknesses of both qualitative and quantitative methodologies. While this can be challenging, employing a mixed-methods strategy can give a researcher a clearer picture of a complicated phenomenon or situation.

Discussion of Methodology

This study conducted a mixed-method design utilizing both qualitative and quantitative strategies. More specifically, a convergent parallel study design was used. A mixed-method design was appropriate for gathering primary data from experimental surveys to support the findings from quantitative and qualitative research methods such as literature reviews and case study analyses. In addition, it gave a representative to the problem statement to address management's failure to provide high-quality hospice care in healthcare facilities, resulting in quality control issues and customer dissatisfaction within the hospice centers.

The qualitative data design gave it a classic literature response and decision-making process that connected the mixed-method design to a convergent parallel design (Johnson & Christensen, 2019). The convergent parallel method approached the research question from a practical and theoretical perspective. It incorporated multiple concepts and techniques in collecting numerical and textual data, which could not be gathered using a single methodology (McCusker & Gunaydin, 2015). A mixed design enabled the researcher to gain a quantitative and qualitative perspective on quality control issues and patient satisfaction in hospice cancer care.

The parallel convergence method represents the traditional model of a mixed-methods triangulation design (Creswell, 1999). In this design, the researcher gathered and analyzed quantitative and qualitative data on the phenomenon independently, and then the different results were converged by analyzing and comparing the other outcomes. Researchers adopt this model to distinguish results or confirm findings (Creswell, 2016). This study consisted of using computation and continuous variables to produce results. Continuous variables included measuring scales of interval and ratio scales based on the research questions. For example, standard continuous variables in healthcare hospice management consisted of length of stay, wait times, charges, and laboratory test values. Statistics summarized the hospice patients on a Likert Scale of 1-10 and the shape of the distribution of a continuous variable (White, 2016). The critical data characteristics for end-users were the typical value and the distribution data values. This determination helped define the quality-of-care issue and understand its effectiveness by examining predictable results for a larger community (White, 2016). A quantitative method was also used because this study aimed to authenticate the connection between statistically measured variables (McCusker & Gunaydin, 2015).

Shekhar et al. (2019) asserted that mixed-method findings often show different phenomena and not the other aspects of one phenomenon, giving insights into various treatment aspects of hospice care for cancer patients. However, it is worth noting that collecting qualitative or quantitative data electronically comes with several limitations that should always be considered when deciding whether to collect qualitative or quantitative data in person or not. Overall, it presents a more in-depth and broader understanding of phenomena (Schoonenboom & Johnson 2017). Kluge et al. (2019) posited that mixed methods generate a better understanding of a given theory or phenomenon that offers an emerging trend, and thus matches the research's complexities.

Explanatory Sequential Method

The explanatory-sequential approach denotes following quantitative results with qualitative data. Creswell (2016) showed how, in mixed-method studies, quantitative and qualitative methods enter into a secondary process with a concurrent analysis (quantitative or qualitative) after the researcher's interpretation of the results from the initial quantitative forms. Using this research design required following a sequence and choosing the approach to prioritize. The sequential explanatory design prioritized the quantitative approach. The researcher collected the quantitative data before sequentially incorporating the qualitative approach in the second data collection phase. However, delivering the true nature of research and responses did not rely solely on the qualitative or quantitative data, but rather on both equally (Creswell &Creswell, 2018).

Discussion of Explanatory Method

A qualitative method was not used in this study because it could not authenticate the association between variables and the research questions (Creswell & Poth, 2018). Creswell (2016) stated that the two-phase process approach is beneficial for a researcher interested in explaining the research findings. This research focused on better quality management in hospice health care and closing quality gaps. The mixed-method design provided more in-depth insight into these underlying aims. This study consisted of gathering information through a mixed-method study. The mixed-method design highlighted the researcher's focus on exploring management's failure to provide high-quality hospice care in the healthcare facilities, wherein the components of time and hospice location are of importance. This approach is commonly employed by researchers who are more comfortable with quantitative research, in which weight is given primarily to the quantitative findings, which explains why this strategy is considered explanatory.

Qualitative research manipulates concepts in historical data, rather than numbers, and applies a naturalistic approach to examine social circumstances, notions, and underlying ideas that influence performance in a natural environment (Ruel, 2017). Examples of qualitative research approaches include phenomenology, grounded theory, narrative, ethnography, and case study. Applying the quantitative research method alone was inadequate for the historical comparison of data, literature review, and qualitative data analysis. However, integrating both methods in this study provided helpful insights and facilitated an in-depth understanding of management's failure to provide high-quality hospice care in the healthcare facilities.

Exploratory Convergent Parallel Method

The exploratory nature of the research necessitated investigating the hospice management of multiple centers across the United States through observation, overview documents, artifacts, narratives, ethnography, descriptive or inferential statistics, and automated measures. This study's exploratory convergent-parallel approach method was built on the preliminaries that identified research questions. McCusker and Gunaydin (2015) showed these as starting fundamentals of the qualitative phase of data collection and review. Following this was quantitative data collection analysis, and then a final phase of linking of data from the two separate strands of data. Finally, this method included the transformative stage recommended by Creswell and Poth (2018), in which a mixed transformative framework included exploration using a qualitative approach. The exploratory convergent-parallel approach method for this research provided a more profound understanding of why a study of organizational effects on hospice quality of care would allow generalization over similar diverse units. Management requires effective leadership to promote the mission and objectives of discovering better processes for hospice patient management, which often result in quality control issues and customer dissatisfaction within hospice centers.

Discussion of Exploratory Method

The exploratory method places an emphasis on an initial qualitative research phase used to gain insight into an understudied phenomenon—hence the experimental nature. The exploratory sequential design also uses sequential timing. In contrast to the explanatory design, the exploratory design begins with and prioritizes the collection and analysis of qualitative data in the first phase. Building from the exploratory results, the researcher conducts a second quantitative phase to test or generalize the initial findings. The researcher then interprets how the quantitative results build on the initial qualitative results. The quantitative method was not used exclusively because it would not validate the relationship between variables and all the study questions (Creswell & Poth, 2018). This research mixed diverse data forms, such as participant observation, narratives, ethnography, descriptive or inferential statistics, and automated measures (Creswell, 2016). This study did not establish an explanatory or exploratory, sequential, or convergent framework. Instead, a convergent parallel design helped discover more valuable methods for hospice patient management in seeking truth and discovery. The customary use of this strategy is to perform qualitative research on a specific phenomenon or with a particular population and then use this information to develop an appropriate survey instrument to collect quantitative data. Because the goal of sequential strategies is to use one step of the research to inform one’s findings, sequential procedures can take a long time to conduct. This type of research design emphasizes the research aspects and details the result (Schoonenboom & Johnson 2017).

Discussion of Triangulation

Triangulation brings attention to mixed-methods research at the logical step through consolidating quantitative and qualitative data. Triangulation utilizes multiple data references to assist mixed-method design research in a comprehensive understanding of the purpose of the study (Creswell, 2016). The concept of triangulation in this study presented a validation process which evaluated the trustworthiness of material science for the study outcomes. Alternative aspects of triangulation study were its utilization as an analytic means. For example, the purpose of the survey was to solicit a more in-depth understanding of study findings and clarify research question outcomes by setting them in dialogue with one another. The dialogue developed the theory through triangulation that employed various theories to evaluate and examine the data (Kluge et al.,2019). Data origin within triangulation was a methodical approach for evaluating and assessing documentation as a data source for this research (Creswell & Poth, 2018). Overall, given the process of data gathering quality, the researcher stayed anonymous and used data sources in the triangulation process to validate the conclusions.

Summary of the Nature of the Study

In summary, the researcher utilized this research paradigm to define the scope and critical components of the paper. This ensured that the research questions were adequate in design format by discussing the primary quality control issues and potential improvement solutions for improving hospice care for cancer patients. Furthermore, a mixed research design utilizing a convergent parallel study harmonized idiographic knowledge with nomothetic knowledge from qualitative and quantitative sources.

Conceptual Framework

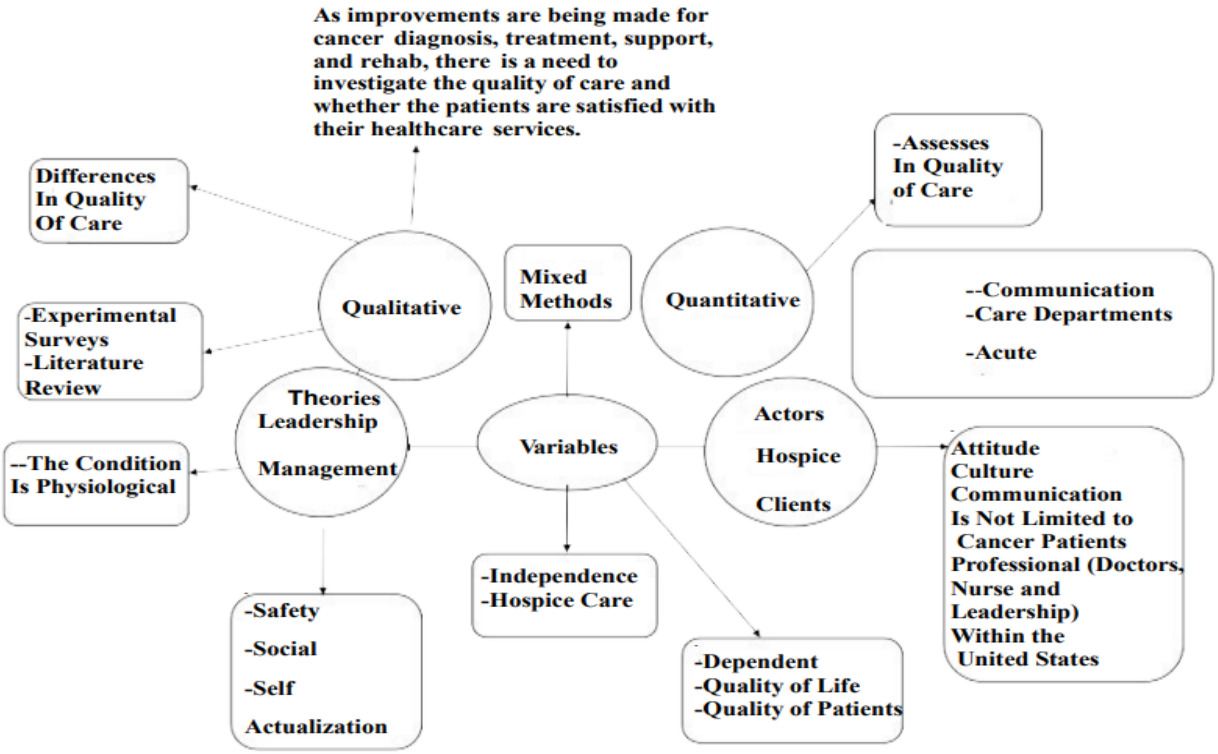
Hospice management among cancer patients in the United States aims to significantly improve their lives through pain relief and suppressing other distressing symptoms. Notably, advancements in the health profession have led to a significant improvement in detecting and treating various varieties of cancer, including but not limited to cervical cancer, mouth cancer, and prostate cancer. However, researchers indicate that nearly half of cancer patients die after one year of being diagnosed with a malignant disease (Perumalswami et al., 2019; Sey & Hunter 2020). Statistics indicate that more than 500,000 people die every year from cancer in the United

States alone (Jemal et al., 2020). Hospice management is crucial in guaranteeing each patient their last moments with their families and improving the cancer patients' experience. This phenomenon aims to ease the patient's pain without attempting to cure a disease that results in a high probability of death (see Figure 1).

Speculation surrounding hospice care linked back to the purpose of the research, and the question of how to define the quality of patient care. ASCO (2016) theorized about the proper definition of care. The National Health Service (NHS) interprets good care as selecting, availability, and outcomes for the interventions (Johnson et al., 2020). This definition extended to the guidelines used in this research. These guidelines concentrated on patient engagement and the research questions. The researcher asked the patients about availability, consent, and transparency, based on three concepts outlined by the NHS. Hospice care management must have a well-documented system and the availability to perform at high standards. Patients need to be given adequate information concerning all interventions and having patients involved in any discussions (Johnson et al., 2020). Figure 1 shows the relationships linking research concepts and inputs and how they correlate the actors, variables, and theories. Additionally, the frameworks offer ways to better understand the critical parts of this research.

Figure 1

The Concept Mapping



Note. Ventegodt, Merrick, & Andersen (2003).

The framework application used to conduct this research necessitated a mixed-method design. The theory employing the Chi-squared Test of Independence recommended by White (2016) showed realistic approval to patient flow by analyzing the relationship between variables. The chi-squared represented Figure 1, variables, theories, and symbols as χ2 (where χ denotes the Greek character chi). This study was a statistical test for examining relationships between categorical variables. In this study, a chi-squared test generated by hand made the examination more manageable (White, 2016). The initial step in utilizing any hypothesis testing process in statistics is understanding the null and alternative hypotheses (Creswell, 2016). In the employment of the chi-squared test, the null hypothesis has no relationship between the categorical and independent variables. To do so requires the mixed-method design framework. In this study, the theories supported leadership and management styles for better patient quality of care—these concepts framed Maslow's motivational theory for better performance by hospital administrators and staff across the United States. A chi-squared test created a justification within the variables to determine if the results from patient representations could be generalized to conclude a difference in proportion within the hospice system.

The Concepts of Research

As improvements are made in cancer diagnosis, treatment, support, and rehabilitation, there is a need to investigate whether patients can receive better healthcare services. The is especially true as healthcare becomes more sophisticated and multidisciplinary. Patient satisfaction can help to identify improvement areas and develop improvement strategies. It is necessary to conduct regular patient satisfaction surveys for cancer patients, considering the extensive and debilitating nature of the treatments they often must undergo. Patient satisfaction, especially in hospice care, is just as important as the care itself. According to Pati et al. (2017), a cancer patient who suffers from the disease experiences significant agony, stress, trauma, uncertainty, and apprehension. There is a need to improve access to hospice care management for cancer patients' quality of life (QOL) and experience. Patients with advanced cancer and their families often confront management barriers to hospice access and challenges to integrating hospice cancer care (Haverhals et al., 2019). This study aimed to relieve that stress and other distressing advancements, and to enhance management leads by employing the theories and variables noted in Figure 1.

Patient satisfaction significantly affects mental and physical health (ASCO, 2016). Evidence suggests that health outcomes depend primarily on satisfaction with health-related behaviors, patient compliance, and the motivation to seek care. On a global scale, patient satisfaction is affected by the quality of service received. Many patients do not feel satisfied with their care, especially at the end of their lives (ASCO, 2016). It is essential to have excellent management and leadership, and to have a mission statement leading to a theory. Maslow's motivation theory was used in this study. This theory was relevant to the study's problem statements regarding management's failure to provide high-quality hospice care in healthcare facilities, resulting in quality control issues and customer dissatisfaction.

Theories

This research followed Abraham Maslow's theory of the principle of the hierarchy of needs. The concept framework proposed that individuals seek to satisfy progressively stronger human desires beginning with physical requirements, such as food and shelter, safety and security, esteem, and self-actualization (Dohlman et al., 2019). Maslow's motivational theory addressed the need to meet quality control and pivotal needs like physiological and safety to reduce anxiety during symptoms and suppress pain. Finally, family members must be present to provide patients with emotional support and address basic needs before moving on to satisfy other needs or so-called higher-level needs (Hinojosa, 2019). Maslow's motivational theory was relevant to the study since it outlined five critical conditions necessary for the quality of care for the patients. These conditions were physiological, safety, social, self-esteem, and self-actualization (Ventegodt et al., 2003).

Leadership management theory was also critical to this study. This theory translated the study process and inquired into the management process as it manifested in different variables of the study. Traditionally, many managers perform leadership roles, and many leaders manage daily functions, but in the hospice process—during which an individual mobilizes people and resources—leadership empowers nurses and aids. Leaders are necessary for hospice care to meet patients' needs and ensure integrity, quality of life, and function (Johnson et al., 2020). This study addressed these issues through interview questions relating to pain management, quality of life, and fulfilling the patients' end-of-life wishes. The research employed an examination of cohort concepts on patients and a literature review. According to previous research, patients who received hospice care experienced better end-of-life treatment than those who did not accept hospice care within the United States (Haverhals et al., 2019; Johnson et al., 2020; Osagiede et al., 2018). Some patients receiving hospice care in the home were given medication to manage their pain symptoms. In contrast, the patients in the control-centered hospice group did not receive any pain medication. However, most of the patients in both groups reported pain symptoms, and the families of the patients who received hospice care reported that their pain management regimes coordinated well with their signs at some inpatient care centers (Osagiede et al., 2018).

The foundation of this study focused on Maslow's theory. The variables considered were the *Independent Variable* (Hospice Care), *Intermediary Variable* (Leadership Management), and *Dependent Variable* (Quality of Life of Patients) (Ventegodt et al., 2003). These foundations offered a focal point to the research concepts and addressed the general problem statement concerning management's failure to provide high-quality hospice care in healthcare facilities, resulting in quality control issues and customer dissatisfaction within hospice centers.

Actors

Different actors played an essential role in improving life among patients in hospice management, including but not limited to healthcare professionals, the community family members, and other people diagnosed with the disease as they provide support in a time of need. Every actor was thereby essential and was analyzed further within the study. The relevant actors in this study included but were not limited to cancer patients, cancer care professionals, families, and relatives of the patients and acute care departments in the United States. The healthcare hospice industry was the target industry in this study. The survey of the actors in healthcare hospice management focused on traits within the recent literature and investigated research questions in the discussion of management processes based on quality care and facility management. Employing Maslow's motivational theory addressed quality control and pivotal demands like physiological and safety to reduce anxiety during the treatment of symptoms (Dohlman et al., 2019). The hierarchy of needs offered an overarching theory of motivation that sought to counter existing motivational theories.

Using Maslow’s theory, Lussier (2019) explained the impact of managers and leadership needing motivation, especially within the American business hierarchy. The management process creates importance, which reflects the hierarchy of needs through redesign programs and quality care. Simões (2020) asserted that certain actors face challenges when adapting to new and unpredicting circumstances under which the hospice care nurses must continue providing quality care to cancer patients and their families. Cancer care is different from treating other sicknesses (Gomez-Cano et al., 2019). Cancer care delivery depends on patient satisfaction, improving patient outcomes, and responding to treatment. Since the patient struggles with many other issues, including trauma, financial problems, mental agony, and uncertainty of life, any cancer care hospice must be mindful of its satisfaction with the care provided.

Variables

This research incorporated three prototypes of variables: independent, intermediary, and dependent variables. Creswell (2014) posited that the independent, intermediary, and dependent variables have uncertainties that stream from mixing or connecting quantitative and qualitative data. These variables pointed directly into the problem statement to maintain the best possible quality of life for patients, allowing them to choose the type of treatment they wish to have while managing the sickness. Another principal aim should be meeting the patients’ needs when their illnesses advance by offering them adequate symptom control. Pain is often a symptom before death. In dealing with pain, symptoms such as nausea, distress, confusion, and many other psychological and physical conditions often go undertreated or untreated and vastly lower the quality of the patient’s life (ASCO, 2017). This study focused on the independent, intermediary, and dependent variables, as outlined below.

Independent Variable

Independent variables were integral to the overall hospice management process, including early detection, treatment, and patient motivation. Creswell (2014) defines independent variables as a probable cause that affects the dependent variable. Hospice care was an independent variable and encompassed all the services for cancer patients, including early detection, treatment, and motivation. In hospice care, the stage of cancer diagnosis is assessed, and the proper treatment is determined. Mitigating factors such as sex, age, marital status, and ethnicity ensure a patient has the best experience during this period.

Dependent Variables

Dependent variables were the outcomes and feedbacks of hospice management measured using a mixed-method design. Creswell (2014) defined dependent variables as variables that directly depend on the independent variables, and whose results impact independent variables. Patients' quality of life was a dependent variable and was measured through mixed-methods according to the patients' feedback and those of other actors involved in the study. The variable sought to trace the progress of patient care in hospice. Stakeholders evaluate the severity of patient symptoms across time to ensure that patients receive adequate care. Health practitioners consider primary tumor sites to assess severity, spread, or improvements in patients. The variable measures showed how patients' welfare needed enhancement through proper follow-up by all stakeholders.

Intermediary Variable

The intermediary variable encompassed Maslow's motivational theory. This variable defined acquaintance management leadership and information practices (Abualoush et al., 2018). The variable sought to pursue management style leadership in the hospice patient experience. The study encompassed Maslow's motivational theory with a practitioner focus on the stakeholder evaluation concept.

Figure 1 demonstrates a conceptual framework for hospice management of patients that shows a diagnosing concept with cancer patients in the United States, where more than half a million people succumb to the disease every year (Haverhals et al., 2019; Johnson et al., 2020; Osagiede et al., 2018). Different theories suggest ideas like in Figure 1, which includes Maslow’s motivational theory and addresses various needs among patients with cancer in hospice management. Such conditions must meet quality standards, including physiological conditions such as intake of food and water. Patients must also feel safe when undergoing pain relief and symptom suppression. Secondly, patients with a breast cancer diagnosis may have low self-esteem as some may feel sexually withdrawn. However, hospice management therapy can alleviate these forms of anxiety (Bergerød et al., 2020). Actors in these situations include cancer patients, families, healthcare professionals, and departments that are related to acute care. Other actors must understand that they are required to maintain a caring attitude. They must also consider the unique traits of the patient. The stakeholders must be willing to obtain consent and consider cultural needs. Thirdly, every patient or their surrogate has the right to choose the location of care and providers. Finally, communication must be maintained (Abualoush et al., 2018). With regard to the conceptual framework which addressed the hospice management communication process, the different variables presented in Figure 1 had to be considered:

1. The probable cause must address whether or not to take on hospice management issues.
2. It was crucial to understand that an intermediary variable relates to managing information where different healthcare professionals must be ethical to provide good communication and allow the patient to take on treatment or continue trying to cure the disease.
3. The dependent variable's role was closely related to how different stakeholders, healthcare professionals, and departments of acute illnesses interact to make hospice management a success.

Hospice management of patients with diagnosing factors in cancer aims to relieve pain and suppress the disease's symptoms. Hospice management is determined successful through three different entities, including Maslow's theory, which hopefully fulfills the patient's needs (Kweku & Hunter, 2020). Various actors, including families, have different roles that must ensure consent is in place. Doctors, along with the various departments that must provide drugs to relieve pain, must also provide sufficient information when deciding to practice hospice management. This discussion necessitates highlighting other variables, including dependent and intermediary, which make hospice management a success. The framework highlighted different variables involved in hospice management, including an independent variable that constituted the overall hospice management, dependent variables that affected leadership management, and intermediary concerns with Maslow's theory. Finally, the framework outlined different actors' roles, including healthcare professionals, patients, and family members. To summarize, the conceptual framework adopted in this study highlighted the theories that include Maslow's motivational theory concepts.

Relationships between Concepts, Theories, and Actors

As healthcare regulations develop, facilities management demands assurance of high-quality hospice care and customer satisfaction within hospice care, ensuring proper patient outcomes (Perumalswami et al., 2020; Yabroff et al., 2019). An increase in hospice management levels helps ease pain experienced by cancer patients and improved their subsequent life experience by suppressing cancer symptoms, thus helping to diagnose it at different levels (Collett et al., 2019; Haverhals et al., 2019). In the last century, there have been advancements in the early detection and treatment of cancer types (Bergerød et al., 2020). However, current statistics reveal that almost half of the patients diagnosed with cancer typically die from cancer after at least one year of diagnosis (Kweku & Hunter 2020). This results in an annual death toll of half a million cancer patients in the United States (Bergerød et al., 2020). However, various research works reveal that early detection of a cancerous growth can improve the patients' quality of life, since interventions offer real-time action and prevent the disease from advancing (Haverhals et al., 2019; Johnson et al., 2020; Osagiede et al., 2018). Improvement in hospice management improves the quality of life of patients as it increases their lifespan and helps patients to agree on the preferred site for treatment. At the same time, it relieves them of pressure and saves time that may be wasted while searching for the cure of the disease (Haverhals et al., 2019). The research framework addressed these issues through a critical analysis of the actors, theories, and variables.

Summary of the Research Framework

The conceptual study framework applied the mixed-method design structure. This framework centered on the study's theories that pointed to leadership and management styles for better patient quality of care and the role it plays in the healthcare industry. This focused role can help the environmental and operational circumstances that are evolving. The evolving factor in this study helped with the study design in employing a mixed-method, creating a justification for a quantifiable portion of the study by using a chi-squared test that produced an explanation within the variables to determine if the results from patient representations can be generalized to conclude a variation in proportion within the hospice system.

An in-depth investigation of the topic identified the various determinants and drew a correlation to these problems. Studying this subject made it possible to develop further recommendations for healthcare administrators and policymakers to improve hospice care, decrease mistakes, and promote ethical healthcare systems.

Definition of Terms

Autonomy: Hospice care patients' right to make decisions concerning their medical care without their healthcare provider attempting to control their choice. Understanding the subject as an autonomous being factors in their state of mind and correlates with nurse-patient relationships and their impact on the quality of care and the patient's decision making (Molina-Mula, J., & Gallo-Estrada, 2020).

Burnout: Hospice care job-related intense crisis can cause emotional and physical fatigue over a widespread period with people who encounter psychological and physical dilemmas. Schaufeli et al. (2017) showed these essential features of burnout, as extreme fatigue experienced by highly trained and competent workers.

Chi-squared Test of Independence: The Chi-squared Test of Independence is an approach set by author White (2016) that presents practical approval to patient progress by examining the association between variables. The chi-squared test referenced in Figure 1 denotes variables, theories, and symbols as $\chi 2$ (where χ denotes the Greek character chi).

Comfort Care: This is a process of continuous home care administered to patients with more rigorous and acute medical symptoms. Consideration is given for patients between 8 to 24 hours a day by qualified nurses in the annex to hospice aides to relieve pain or symptom crisis (Morita et al., 2017).

Compassion Fatigue: Indifference to human emotions on the support of those suffering, encountered due to the frequency of pain to quality of life (Jo et al.,2020).

Dependent: Dependent (nonprofit) hospice facilities that focus on management designs in hospice care are fundamental components of high-quality hospice care (Boros, 2021).

End-of-life: Centers for Disease Control and Prevention (2021) defines patients whose cancer diagnosis is six months or shorter as the end of life.

General Inpatient Care: This process is provided when pain and acute symptoms need to be treated in a selected hospice center such as a Medicare-certified hospital, hospice inpatient center, or nursing center. Once again, a 24-hour nursing team must implement primary patient care, and the patient's home is no longer in the picture (Lattanzi-Licht et al., 2018).

Hospice Care: Hospice care is a variety of healthcare that concentrates on the terminally ill patient's pain and symptoms, and also manages their emotional and spiritual demands toward the end of life (Lee et al., 2018).

Independent: Independent (profit) hospice facilities that concentrate on administration plans in hospice care are fundamental components of quality care in hospice centers (Mutebi et al., 2020).

Inpatient Hospice Care: This process serves as a relief system for the patient from their primary facility, sometimes a family member, a designated hospice facility, or another certified facility with 24-hour nursing personnel. At this period, the patient is no longer in their home (Hughes et al., 2020).

Leadership Management Theory: Leadership management performance is a system of rewards and punishments. Hospice leadership represents intermediary services that offer a wide range of services (World Health Organization, 2021).

Lifelong Length of Stay (LLOS): The average length of stay for patients. Data shows more Medicare patients enrolled in hospice and LLOS 89.6 days, leaving an expectation placed on the management and nurses (NHPCO Facts and Figures, 2020).

Maslow's Theory: Maslow's Theory asserts motivation concepts that set five classes of human obligations to formulate an individual's behavior. These obligations are physiological demands, safety obligations, love and belonging wants, esteem wants, and self-actualization wants (Lussier, 2019).

Outpatient: Hospice patient who accepts medical procedures without being admitted into a hospital; in most cases to a clinic or particular center for outpatient treatment (Handzo et al., 2020).

Reimbursement: Invoice payment rates are intended to incorporate costs in return for incurring furnishing services recognized in patients' care plans (White, 2016).

Routine Hospice Care: This is the most traditional model of hospice care. The patient has elected to receive hospice care in the convenience of their private home. Hospice staff are committed to implementing the required services to reduce pain and maximize comfort (Mathews et al., 2021).

Trained Volunteers: Assist in providing patients and families with compassionate care and assistance during the end-of-life means (Walshe et al., 2021).

The Quality of Care (QOC): The concept of enhancing the quality of life and accommodating patients, hospice care can improve patients' understanding of their medical treatment choices (Walker & Mcmillan, 2021).

Quality Control Issues (QCI): Define how hospices cope with burnout, understaffing, and aging population. Recognizing these industry-wide problems can contribute to our understanding of how to address these impediments (Khare et al., 2016).

Quality of Life (QOL): Defines the standard of health, comfort, and happiness for patients (Molina-Mula., 2021).

Assumptions, Limitations, Delimitations

Assumptions, limitations, and delimitations impact the study, creating transversal boundaries. These boundaries can affect survey interviews, so limits were specified in written instructions for the participant during the IRB approval process. Leedy and Ormrod (2021) posited that assumptions are fundamental and provide focus on the study's problem. However, the study problem itself cannot exist without the assumption factor (p. 62)—denoting those elements results in areas of the investigation that may have vulnerabilities within the study. Such a focus helps one to avoid potential influential processes in the study for which delimitations data control might present better accuracy (Osieja, 2016). The delimitations factors limited the scope and defined the boundaries within the research.

Assumptions

Assumptions in the study implied ideas and theories assumed to be valid to the researcher or reader without proven assumptions; in focusing on this study's assumption, hospice staff and facility centers across the United States who were participants in this research underwent a survey of quality in the management processes (Leedy & Ormrod 2021). The study process within the survey question assumed that the participants would be nursing staff and members of the hospice industry and would be open to the prototype of industry-standard in having a more immeasurable quality of care over issues. Accomplishing such, the implementation would describe the investigated problem statement in quality issues within hospice centers. Each assumption warranted a process of ethics and standards, for example, voluntary participation, the anonymity of participants, and signing participant forms before the survey was conducted (Osieja, 2016).

Limitations

The limitations of this study were that it focused on for-profit and nonprofit hospices centers. The quality of care was assessed in selected centers through the use of the interview process. The research scope was generalizable to a more extensive hospice organizational field. In terms of relevance for this research, Maslow's Theory and Leadership Management Theory were applicable to the research topic at hand. In other words, hospice management administrators' specific practices, strategies, and philosophies may not be directly relevant to other hospice operations in the field. For this reason, the limitations were that it presented directions, courses, and collected data that were primarily geared towards hospice organizations

(Osieja, 2016). Mitigating this limitation required focusing on the overall results and restricting the scope of the intermediary management QOC of the hospice participants chosen for the interview. The study utilized the medical record of the Research Institution organization within the United States. In doing so, it limited the more extensive hospice organizational field and gave the researcher less influence outside of the hospice venues (Leedy & Ormrod 2021).

The literature review examined concerns that originate from history. Given the scope and variety involved in hospice care, the management perspective may be insightful within the work atmosphere. The continuously evolving body of work on this issue points to fundamental management differences between the administration process that may help the demand for end-of-life care. This can help researchers to recognize issues within the hospice industry.

Delimitations

The scope and delimitations of a study refers to the boundaries that can make one’s analysis more manageable and relevant (Roseveare, 2017). The participants of this research were limited to those involved in the hospice patient experience in cancer care services. This delimitation allowed for the organization’s aims to enable generalization over several comparable factors. It comprised the intense, methodical examination of data correlated to different variables.

These different variables included aspects of management including administration, nurses, and patient experiences. Patients are directly affected by the responsible practice of the management method and leadership. This approach narrowed down the comprehensive, complicated issue of the organizational situation into manageable practice by focusing on the research question: what improvement interventions should U.S. hospitals adopt to manage cancer patients efficiently? Overall, this approach allowed the study to combine qualitative and quantitative data sets and gave it a mixed-method strategy.

Significance of the Study

Hospice care management was the explicit focus of the research. This focus aimed to maintain the best possible quality of life for patients, by allowing them to choose the type of treatment they wish to have while managing cancer. Prior studies show that multiple factors in hospice care limit the utilization of these services, which highlights the need for further study on this issue (Johnston et al., 2020; Meier et al., 2017; Nagata et al., 2021).

Reduction of Gaps in the Literature

There has been an increased awareness of patients’ perception of the quality of healthcare in recent years. As a result, it has become imperative to measure patient satisfaction as a mechanism for obtaining attention and value for healthcare consumers and competitors. Healthcare professionals have also had to develop systems to measure patients' perceptions and satisfaction with their care. Patient satisfaction measurement involves evaluating their opinions and determining whether the patients felt that their needs were met. They sometimes show gap reductions that reflect poorly trained managers, managing interruptions of the attending physicians, high staff turnover rates, and the ineffective processes utilized by the hospital administrators (Johnston et al., 2020; Meier et al., 2017; Nagata et al., 2021). The design of this study focused on the patient satisfaction survey method, the objective, and the systematic method of determining the cancer patient's perceptions about their healthcare.

People who are diagnosed with cancer face many physical, psychological, and educational challenges. A patient diagnosed with cancer is vulnerable to developing stress resulting from the definitive diagnosis, the treatment of cancer, and the possible prognosis. Therefore, cancer patients are prone to developing emotional disorders such as traumatic stress, anxiety, and depression (Brothers et al., 2011). The patients can become even more stressed due to long durations of time spent in the waiting room, lack of information about their condition, poor communication between the patients and the healthcare staff, and psychosocial assistance (Cornelius et al., 2020).

Implications for Biblical Integration

Health management incorporates Biblical principles in the process and in everyday activities, through unconscious and deliberate processes (Smith et al., 2019). Our decisions in life or practice management are guided by Biblical principles (Methuen, 2017). Leadership should appreciate the relevance of Biblical principles because they inform workers in the daily processes. This study considered the QOC components, such as the research question, ethics, methodology, and results, from a Biblical perspective.

The Bible's views in this arena of health management are vital. The Bible is the Word of God (Methuen, 2017, p. 9) and is an example of the oldest historical research that reveals the world's origins. Effective management requires the ability to think, learn, and train—all of which are God-given. Therefore, quality in health management can be endorsed by God because of the human body's intricacies. These intricacies give a great value to human life, transcending the quality of life and giving the almighty God responsibility for our lifestyle and healthcare choices (Lagman et al., 2021).

The Bible, specifically in the Ten Commandments, shows the critical concept of ethics, guiding leadership, and management behaviors that are integral to the hospice care process (Methuen, 2017). The application of ethics was involved in the QOC composition, recruitment, staff, and management process (Sileyew, 2020). The methods used in the Bible are woven in its stories, histories, passages, prophecies, and chronology, which are all systematic and orderly. Such principles guided the current study in the hospice management design to adopt a methodology that yields reproducibility and faith in the daily decisions made by leaders.

The Benefit to Business Practice and Relationship to Cognate

The benefit of pursuing a healthcare management cognate relates to the discipline, leadership, and management skills that comprise the daily organization process. Healthcare management provides leadership and direction to corporations that deliver personal health services and guidance (Peter et al., 2020). Turner (2017) described healthcare management as a form of talent management. Talent applies to personalities in the health arena, such as the professional expertise involved in delivering quality care to the patient.

The goal of this study was to enhance the services in healthcare practices. Improving leadership has the potential to effect advancements in quality care for patients. Regardless of the specific hierarchy position, managers are expected to carry out the management duties to guarantee the adequate provision of high-quality healthcare services. This necessitates the preparation, organization, and management of several activities to provide services safely and efficiently. In this manner, healthcare managers must interact with experts and other managerial staff, workers, and healthcare users to build an atmosphere that encourages leadership competencies and fulfills institutional aims and objectives (Peter et al., 2020).

Summary of the Significance of the Study

This research aimed to measure end-of-life care experiences and incorporated various content areas and practical problems for hospice survey administration. Future studies should improve examinations and administration procedures so that care experiences can be reliably aligned and differentiated across care environments. The Biblical view of research discussed above highlights the ethics, methodology, and outcomes. All the components prove that there is a close relationship between Biblical principles and research.

Review of the Professional and Academic Literature

The literature review examined existing literature on hospice care professionals and their patients and discussed the mixed-method research approach. The objective of the literature review was to investigate the inefficient management of hospice care services by hospital leaders, resulting in quality control issues and customer dissatisfaction within the hospice center, and dynamics such as burnout and compassion fatigue (Abu-Odah et al., 2020). The literature review provided a comprehensive understanding of the factors in patient satisfaction and the fulfillment of cancer patients' wishes at the end of their lives.

The depth of scholarly articles shows the determination of what contributes to and inhibits the better utilization of quality control issues (Johnston et al., 2020; Meier et al., 2017; Nagata et al., 2021). This literature review also discussed the conceptual designs and established relationships between research concepts, thus connecting information and correlating the actors, variables, and theories. The conceptual diagram in Figure 1 focused on Maslow’s Theory and Leadership Management Theory. This study required a quantitative process component that employed the Chi-squared Test of Independence, an idea set by author White (2016) that confers realistic support to analyze the relationship between variables. The study concentrated on understanding the quality of hospice care and determining whether it can be improved through patient experience with better management within hospice care in the United States.

An exploration of fundamental terminology correlating to the large body of literature discussed in this section included original works dating back to 1999 from different scholars and peer-reviewed articles as recent as 2021.

The keywords used included Autonomy, Maslow's Theory, Leadership Management Theory, Quality of Life (QOL), Comfort Care, Chi-squared Test of Independence, Medicare and Medicaid, Trained Volunteers, Reimbursement, Burnout and compassion fatigue, the Quality of Care (QOC), Quality Control Issues (QCI), Hospice Care, Lifelong Length of Stay (LLOS), End-of-life, Independent, Dependent, and Inpatient vs. Outpatient.

The central scholarly databases utilized incorporated: BioMed Central, EBSCOHost, Elsevier, Jones & Bartlett, ProQuest, PubMed Central, ResearchGate, SAGE Journals, VitalSource, and ScienceDirect.

Business Practices

Hospice care is a complicated problem that has received scrutiny lately due to the recent volatile growth in the growing population of older Americans. The sector's accelerated growth has sparked the continuing debate relating to how to best provide end-of-life care in terms of quality of life, cost-effectiveness, and compassion care to a growing population. The need for high-quality cancer care in hospice healthcare facilities in the United States results in quality control issues and customer dissatisfaction among cancer patients. The National Cancer Data Base (NCDB) shows different cancer data from 2010 to 2021, ranging from breast, colon, lung, melanoma, and prostate cancer. NCDB data also indicates inpatient vs. outpatient outcomes. The described percentages and associations between inpatient and outpatient care results for patients, facility, and geographic characteristics were evaluated through multivariate logistic regression (Centers for Disease Control and Prevention, 2021a; Lawler et al., 2020).

Since the authorization of hospice benefits in 1983 under Medicare, hospice healthcare has undergone an enormous shift. In the initial years after this endorsement, only a few hospices were for-profit. However, as time has passed, more of these care centers have shifted to for-profit organizations, changing enrollment patterns. According to Thompson et al. (2012), this shift has affected the management of hospices and the quality of care given to enrolled patients. The enrolment period for most Medicare beneficiaries is five days or shorter. However, some patients stay for longer, depending on the severity of their conditions. The average period of enrollment for some patients has, however, been increasing over the years. For instance, between 2000 and 2010, there was a 60% increase in the most extended enrollment period to 240 days from 141 days. This shift is among the factors responsible for the transition of non-profit hospices to for-profit ones.

Further national studies have shown a variation between their enrollment patterns, citing that for-profit hospice often enroll patients whose length of stay is likely to be extended to increase their profits, such as patients not diagnosed with cancer, those with dementia, and other less complicated chronic illnesses (Thompson et al., 2012). This particularly inconveniences cancer patients in terms of access to quality care. Additionally, for-profit hospices were considered as less likely to provide palliative radiation to their patients because it interferes with their profits. More significantly, for-profit hospices have few qualified staff, limiting their patients' access to care, especially when enrolled patients exceed the available staff.

Central to the lack of adequate quality of care from the Medicare-certified hospices is the issue of prioritization of profits for service delivery. Most of the hospice facilities have focused on maximizing their profits instead of creating positive patient outcomes. While nonprofit hospices have kept draining market share for the past decade, the number of for-profit hospice providers keeps surging. Examination conducted by National Hospice and Palliative Care Organization in 2016 revealed that close to 67% of the Medicare-certified hospices were for profit while the nonprofit hospice facilities comprised only 20% (Geyman, 2018). Besides, a study conducted by the Medicare Payment Advisory Commission (MedPAC) revealed that for-profit hospice facilities accounted for 100% of the newly established during 2017 (Bern-Klug et al., 2021). Many nonprofits committed to offering quality services to patients sometimes find themselves in the challenging situation of having slim margins, while the for-profit ones that focus less on the welfare of the patients take a larger market share. Most noteworthy, the management of the for-profit hospices often focuses on the profit margins instead of the services offered to the patients, thus making it hard to achieve the desired optimal positive patient outcomes. Having management designs aligned to profiteering as opposed to service delivery to the patients sets the foundation for unsatisfactory results among patients (Geyman, 2018).

End of Life Care for Hospice Care

Hospice care in the American health system provides comforting, special health care above the expected standards offered in that health institution. It usually occurs when the treatment seems futile and curing the disease seems impossible, and the patient is near the end of their life (Hospicare, 2021). It focuses on increasing the quality of life and individual lives by managing their pain as well as the signs and symptoms of the disease as opposed to curing the disease and prolonging the patients’ suffering. It occurs when the family, patient, and the health givers agree on losing interest in finding curative treatment for the given disease and the doctor has already given the estimated life expectancy of the person (Hospicare, 2021). Qualified health practitioners and self-volunteers deliver quality patient care in healthcare centers to assist their patients in maintaining their quality of life. However, there is an issue with leadership in these units that affects their efficiency in administering their duty. This study investigated the overall operation of institutions in offering hospice patient treatment and related this to leadership theories.

The Centers for Disease Control and Prevention (2021b) identifies a trajectory approaching end-of-life and defines it for patients whose diagnosis is six months or shorter. Hospice care concentrates on rendering comfort and relief from symptoms and suffering and addresses the patient's psychological, social, and spiritual needs. The placement of patients under hospice care is an end-of-life measure, and during this time, the majority of them only need comfort, privacy, and dignity to feel complete. This can be achieved by exempting them from medical care that is aggressive or intensive and replacing it with efficient symptom management interventions.

Current statistics show that the needs of cancer patients in the United States approaching the end of life are not met sufficiently despite the disease being number two among the leading causes of death in the country (Patel et al., 2018). The major reason for this is the costly and unwanted health services provided to patients in hospices during intensive end-of-life cancer care. As earlier mentioned, the goal of end-of-life care is to keep patients as comfortable as possible. Owing to their diverse needs, the interventions needed may vary. However, failure to discuss the goals of care with patients can result in unwanted health services, hence poor end-of-life care.

Similarly, considering majorities of hospices today are for-profit, the inadequacy of staff results in the provision of low-quality health services, limiting the achievement of end-of-life cancer care goals like comfort and the maintenance of dignity. On the other hand, improving end-of-life cancer care can be achieved in several ways. Firstly, cancer patients in this stage are more interested in comfort, and thus, the management of symptoms as opposed to the continuing of treatment is critical - the key healthcare players should be non-physicians. Secondly, the training of care providers and other non-physician personnel is also essential to facilitate effective patient-centered cancer care at the end of life (Patel et al., 2018). Additionally, studies show that integrating technology enhances communication between patients and their caregivers to manage symptoms effectively.

Consultative Care for Hospice

The goal of consultative care for hospice is to aid a medical team in providing resources and addressing the patient's needs (Wright, 2020). However, this does not mean that patient care is reassigned to the consultant. Like any type of consultation in healthcare, Medicare requires the documentation of consultative hospice care, including the request, the reason for the request, the consultant's opinion, investigation findings, and any other services offered. Under hospice care, consultations are beneficial in providing healthcare professionals with alternatives to palliative care for their patients. The consultations often focus on discharge and continuity of care, end-of-life decision-making, ethical issues, pain and symptom control, and psychosocial issues (Gilissen et al., 2020). While most health experts have the knowledge and skills required to practice curative medicine, the end of life can pose challenges because it has more to do with maintaining a patient's comfort at the end of life. This is why hospice physicians consult about the above issues**.**

Hospice care consultation demands the collaboration of a multidisciplinary team of social workers, psychologists, managers, patients, families, nurses, religious leaders, and other healthcare experts (Gober, 2002). The team may employ services such as music and pet therapists, mindfulness practice with practitioners, massage therapists, child life experts, and grief mentors. The function of families in palliative consultation is to receive advice on how to contribute best to their loved ones' comfort at the end of life. Consultation can also be sought on how to discuss end of life goals with patients who are still in denial about their condition and need help transitioning. Further, educating communities about palliative care and when to seek it is part of hospice care consulting as it enhances their awareness about cancer patient's end-of-life needs.

As such, interpersonal communication in hospice care consultation is crucial to attaining clinical goals (Buchbinder et al., 2019. The consulting and attending physicians correspond using various means, including emails, letters, and phone calls, among others. Additionally, only the attending physician can authorize the transfer of care of a patient under hospice care.

Gomez-Cano et al. (2019) examined the link between overall patient satisfaction and ten essential questions covering the aspects of experience that apply to all patients. Responses to two of the questions concerning care coordination and the care administration experience strongly predicted overall satisfaction. Under the administration of care, the study investigated the degree of patient satisfaction with care by considering the respondent response letters and the availability of correct test results or notes. On the other hand, care coordination assessed the effectiveness of interdisciplinary collaboration in providing quality care to patients.

Jacobs and Shulman (2017) posited awareness of cancer care delivery systems within hospices, which has generated difficulties for implementing optimal follow-up care to patients and survivors living with cancer as a lifelong disease. According to their study, despite reaching permanent survival – which is the period where the recurrence of cancer is potentially unlikely – survivors still suffer the long-term effects of treatment. This is because the consequences of cancer treatment continue to affect the body system for months and even years after. Therefore, the article shows the importance of follow-up cancer care for survivors and the evaluation of their challenges to develop effective recommendations.

The objective of Hutcheson's (2011) article was to show the possibility of educating and supporting development and procedures to address cancer patients' management processes. According to the author, counseling patients enrolled in hospices is among the ways of offering patients effective care at the end of life. Another way is being time conscious when referring chronically ill patients at the end of life to hospices. Finally, collaborating with an interdisciplinary team also qualifies as an effective strategy for delivering quality end-of-life care.

Krisman-Scott (2003) outlines the changes made in caring for dying patients and the events that led to the establishment of the hospice program in the United States. Care for the dying transitioned significantly after World War II with the "depersonalization and prolongation of death" caused by the technological advancement and the hospitalization of the dying. The hospice movement was formed to counter these effects**.**

Understanding the Hospices System

Scholars continue concentrating on debating the fundamentals of the hospice system by discussing its advantages and disadvantages (Tate et al., 2021). While hospice care is meant to benefit terminally ill patients near the end of their life, it does not always guarantee positive results due to some constraints, as proven by the advantages and disadvantages discussed below.

Advantages.

Hospice incorporates general interdisciplinary care from a team of professionals and hospice volunteers. The care mentioned above can involve physicians, home aid, nurses, social workers, chaplains, and trained volunteers to meet patient and family needs (Taylor, 2021). Some of the benefits of the hospice system includes:

Patients and Their Families Have Twenty-Four-Hour Access to Hospice Professionals. Patients and their families have twenty-four hours of access to hospice experts, which enhances care services for patients with chronic diseases (Morgan et al., 2021). Authors Sandgren et al, 2021, asserts that there are specific kind of hospice care, in turn renders comfort, support, and dignity at the end of life, is the right choice when your doctor concludes that your loves one has six months or less to live, and have decided to forgo corrective treatments. Their study focusses on hospice physical emotional, and spiritual quality of life with the help of experts and with option of care provided with home, nursing home, assisted living, or inpatient hospice facility.

The World Health Organization (2021b) shows that access to healthcare experts decreases the mortality rates among patients with chronic disease. The Centers for Medicare & Medicaid Services also recommends that allowing patients with chronic illness to access caregivers at any given time plays a pivotal role in addressing the needs, thus optimizing their overall wellness.

Out Of Pocket. Out of pocket expenses for medication are provided for by Medicare or Medicaid and private insurance, in turn the objective presents an effectiveness of method (Brom et al., 2021). Hospice care services have cost less, because Medicare or Medicaid and private insurance cater to many out-of-pocket expenses for the medication (Singer et al., 2021). The hospice system is cost-effective compared to hospitals due to their short enrollment periods. Additionally, terminally ill patients at the end of life can prevent their hospital bills from rising by enrolling in hospices (Friedman et al., 2002). Through the healthcare insurance plans, the health government agencies have made it easy for patients with chronic illness to access hospice services easily, thus setting a solid foundation for easy access to healthcare and improving patient welfare. The affordability of hospice services to patients with chronic illness makes it easy to achieve the desired long-term wellness in their respective communities (Singer et al., 2021).

Comfort Care. Hospice care also means avoiding unwanted hospitalization and medical treatments. The entire hospice team aims to support the desires of the patient and the family members (Seton & Lamkin, 2020).

By allowing easy access to the hospice care professionals at any given place and time, the program is flexible as the patients with a chronic illness will not need to visit healthcare facilities for the care services. Instead, they will receive the care services at the comfort of their residence, thus making it a more convenient plan (Brom et al., 2021).

Personalized Treatment. Hospices concentrate on treating the person and not their illness, rendering comfort and maintaining the benefit for the patient's life. By focusing on specific patient needs, hospice care will increase an individual's confidence and attitude, thus staying positive throughout the treatment process. A psychological boost during treatment is instrumental in the recovery path among patients with chronic illnesses (Best et al., 2020).

Quality Over Quantity. Hospices prioritize the quality of life over quantity by focusing on the provision of patient-centered care services. Notably, by guaranteeing all time needs to be driven attention to the patients, the hospice care service helps minimize pain and ensure their optimal positive outcomes. In the long run, the care service's overall productivity is measured based on patient outcomes, and quality-driven benefits often win big (Best et al., 2020).

Covers the Needs of the Patients and their Loved Ones. The hospice system tends to the needs of the patients and their loved ones by seeking the input of both patients and their family members (Seton & Lamkin, 2020). Since a significant number of the targeted patients require lifetime care services to manage their chronic conditions, the involvement of their loved ones helps offer them valuable insight into the treatment measures and the needs of the patients. Most noteworthy, the participation of their loved ones is essential as it creates awareness of their patient's progress, thus achieving a positive psychological state in a family or community setting (Best, 2020).

Promotion Of Togetherness. By involving the loved ones in the treatment and care provision process, hospice care services help bring the family together. Notably, family members will be willing to freely share their patient's progress, thus offering supportive care services and strengthening the bond within the family. Therefore, hospice facilitators can accurately affirm that hospice programs promote togetherness among families by encouraging families to spend time with their terminally sick loved ones (Hennessy et al., 2020).

Involvement Of Multidisciplinary Team. The hospice system is instrumental in achieving optimal patient care as it incorporates a multidisciplinary team whose knowledge and skills are essential in providing quality care to patients at the end of life. Broader knowledge scope is critical for setting a solid foundation for better service delivery in the hospice systems as it sets a solid foundation for better outcomes for patients with chronic illness (Sandgren et al, 2021).

Disadvantages

A notable disadvantage of selecting hospice care might occur because of the constraints set on the various phases of treatment. Under Medicare, hospice reimbursement requirements specify a flat per-day amount of money from which all medical expenses must be paid. Overall, it can result in infrequent complications, such as:

Complexity Of Diagnostic Tests. The complexity of diagnostic tests often delays care service delivery making it hard to achieve the desired optimal quality patient outcomes. Notably, diagnostic tests (X-rays, blood works, lab tests) can be delayed and denied because of mandated regulations and costs; these medical tests then become a financial responsibility of the hospice agency. Because these tests are costly and might not always be advantageous, hospice agencies often will not approve them (White, 2016). By delaying the diagnostic tests, the patients with chronic illness are exposed to the danger of other adverse health effects reducing their overall welfare.

Limited Hospitalization. Hospitalization is limited once a patient enters hospice care, thus denying the patient the opportunity to get other services offered in healthcare centers. Though Medicare does cover a short-term hospital stay (called inpatient care) for symptom management, the criteria for admission and coverage for specific treatments are poorly defined, and in most cases, reimbursement is not paid for returning patients (Kim et al., 2020). Thus, if not well planned for, the hospice care program may fail to offer patients optimal quality and timely care services.

Limited Coverage of Diseases. Hospice care services are discriminatory as they only cover a limited number of illnesses. For instance, cancer is considered a lifetime disease and might not be covered, exposing the patients suffering from this illness to further agony (White, 2016). The discriminative nature of hospice care services reveals its inadequacy to improve the welfare of all people in the community. The discriminant validity of the nature of hospice care services by a series of studies in which reveals the needs and capacity in the market and to be used as a research tool in addition to the process of coverages (Oliver et al., 2021)

Negligence Risk. Some hospice centers do not necessarily offer quality care to patients exemplified by neglect and missing home visits. Since the program is home-based in most cases, there are minimal checks and monitoring of the hospice caregivers exposing the patients to the risk of negligence. Notably, unlike hospitalization, where the nurses and other caregivers are obliged to perform their duties under the watch of their supervisors, the hospice programs often lack the supervisory role, thus exposing the patients to the risk of negligence (Cross, 2021).

Limiting Clinic Services. Another disadvantage of the program is that hospice programs often limit the patients from partaking in clinical trials due to their life-prolonging nature. As such, the patients fail to get other services like counseling offered in clinics, thus making it an inadequate treatment measure. Besides experimental treatments, other services that demand costs, such as feeding tubes, are also not part of the program as they may financially constrain the hospice's running (Kim et al., 2020). Most noteworthy, limiting the patients from partaking in clinical trials reduces discovering any other underlying illness.

Ineffective in Reducing Anxiety**.** Hospice care does not eradicate anxiety and fear regarding the end of life for the patient or their family. Not all terminally ill patients accept their fate, and as such, denial is often accompanied by anxiety and fear (Friedman et al., 2002). Similarly, taking care of a dying loved one can take a toll on an individual's emotions. The service is deficient in the psychological healing element that boosts the recovery journey in patients with chronic illness by failing to reduce anxiety among the patient and the loved ones.

Uncertainty Of Caregiver Support**.** Sometimes, caregiver support is not guaranteed. As earlier mentioned, providing care to a dying loved one can be a tedious anxiety-filled process for some individuals limiting their emotional availability. Similarly, physical presence can be limited due to work and other circumstances, leaving the patient at the provider's mercy. This may cause a strain for both the patient and the hospice services provider (Holm et al., 2017).

These advantages and disadvantages impact the requirement of services and skew priorities in balancing shareholders and patients with a course of business practice. With time, hospice care and the organization's accountability become more valuable. America is aging: a maturing population and shifting demographics do not go well for the overall health and hospice care. Seniors, defined as ages 65 and over, currently account for the most critical sector of the healthcare system (Abel et al., 2019). According to U.S. Census Bureau forecasts, one out of five U.S. citizens will be 65 or older by 2030, which means that older people are projected to outnumber children for the first time within history into the decade (Lawler et al., 2020; Abel et al., 2019).

The Quality of Care (QOC)

In addition to enhancing the quality of life and accommodating patients, hospice care can improve patients' understanding of their medical treatment choices. In healthcare, ethical attentiveness governs all decision-making in a field where people's lives are at stake (Walker & Mcmillan, 2021). To begin with, being a Medicare beneficiary allows cancer patients at the end of life to access free hospice care. This enhances their quality of life by relieving them of the financial stress associated with hospital bills and the emotional turmoil of cancer treatment by targeting symptom management. Secondly, hospice works with families by supplementing professional help with caregiver assistance. Considering that numerous terminally ill patients need professional hospice care, caregivers get to bond with their loved ones by helping bathe and feed them. Thirdly, hospice care allows terminally ill patients to decide on where and how the end of their lives should look like by seeking the end-of-life goals from dying patients. At this stage, aggressive care should be eliminated from the equation and replaced with good symptom management to allow the patients to experience bliss and comfort during their final days. The hospice system enables home visits to further enhance the quality of care provided to terminally ill cancer patients by allowing them to accomplish the highest level of physical comfort (Teno et al., 2011). More importantly, hospice care provides grief support to the families of terminally ill patients after their death by allowing them access to a religious leader or a social worker that can help them cope.

Death and Dying

Dying remains a component of life, in commonality with every living thing. Studies have shown that patients that seek hospice care fare better than their counterparts with a similar prognosis who do not enroll for palliative care. Nevertheless, various phases of the dying process are neglected, such as the quality of care and communication with medical association members and family members. Hospice care professionals infrequently screen management mechanisms to overcome these difficulties (Graven & Timm, 2019). For instance, some care professionals miss home visits for patients in the home environment, and such neglect compromises their physical and emotional comfort.

Additionally, failure to communicate effectively with patients and their families can compromise the care they receive. Hospice professionals are meant to assist cancer patients at the end of life to transition smoothly during their dying process. However, since they cannot be with patients all the time, guiding family members on how to help can make the process easier, and that can only be accomplished with effective communication.

Without proper communication, information transfer, including treatment procedures, purposes of care, diagnosis, and social or spiritual support, becomes misleading (Ernst, 2021; Pentaris & Thomsen 2018). For instance, aggressive end-of-life care can be blamed on poor communication, especially where the caregiver does not understand why their loved one is no longer receiving treatment. Understanding the purpose of care – relieving symptoms and pain management – ought to be communicated appropriately to caregivers and family members for effectiveness to be achieved. Another area that demands a practical breakdown of communication is patient diagnosis. Hospice care is limited to terminally ill patients that have a short time to live, and a diagnosis can help get such patients the appropriate end-of-life care. More significantly, social, and spiritual support requires communication – that is – when family members are being counseled to get through grief or when discussing the end-of-life goals with cancer patients in need of palliative care.

These disorders such as advanced cancer, dementia and lung disease often lead to mismanagement with all departments; for example, leaving nurse aids unsupervised when performing preparations for patients, which can result in poor quality care (Pentaris & Thomsen, 2018; Hawkes, 2019). Thus, the need for interprofessional collaboration between the stakeholders is essential for the adequate provision of quality care. Patient's feelings of isolation, loneliness, and depression result in poor quality of care (Jensen, 2017). Therefore, counseling cancer patients at the end of life is essential to eliminating fear and anxiety and facilitating a smooth transition into emotional and physical comfort.

Communication

Comprehensive research has revealed that no matter how knowledgeable a hospice center is, the facility will not operate correctly without good communication with the patient (Newman

& Schwarz, 2018). According to Brighton and Bristowe (2016), communication with terminally ill patients is essential in end-of-life care. Death is a difficult stage and can be hard to process especially for the terminally ill who may not understand the ineffectiveness of their treatment. Talking them through denial can help them attain physical and emotional comfort quicker. Another importance of communication in hospice care is understanding the end-of-life needs of individual patients to develop an efficient patient-centered care plan. As discussed earlier, different patients have diverse end-of-life goals that help them achieve the comfort needed in palliative care. This means that hospice professionals should have discussions with patients about their goals so they can assist them with execution.

Identifying Management

While most people think hospice is a place where terminally ill patients go to die, in retrospect, it is the care that these patients and their families are accorded towards the end of life (Kitzes & Anderson, 2003). Terminal illnesses are incurable and eventually fatal, and thus, hospice care aims to make the remaining days of their life less strenuous in terms of physical pain and emotional turmoil. This is because the prolonged treatment only causes them extended suffering as opposed to providing them relief. Hospice care integrates different professionals in healthcare to form an interprofessional team. These professionals include social workers, nurses, hospice physicians, chaplains, cancer, counselors, and home caregivers. Family members are also caregivers as their assistance is vital in the absence of a trained professional or a volunteer since most terminally ill patients cannot feed or bathe themselves. Besides enhancing the emotional and physical comfort of the patients, the team is also responsible for facilitating a painless and peaceful death for the terminally ill patient (Kitzes & Anderson, 2003). Some of these patients seek care in hospice centers, while others receive assistance from the comfort of their homes. Nevertheless, the palliative care process is the same for each. Tending to the emotional needs of the patient's family is part of palliative care and should be done both before and after the patient has passed away.

The environment is fast and has unforeseen difficulties; the staff and nurses must be prepared with a skilled workforce and the proper management tools and training. Training ensures that both the terminally ill patient and their family are tended to delicately. On the other hand, having appropriate tools avoids delays in providing hospice care to patients in need. Autonomy was a word utilized to describe the obligation of being a hospice nurse (Willaschek, 2011). Besides proper training and management tools, hospice nurses and other members of the interprofessional team should have compassion for their patients and be interested in helping them, hence the use of the term autonomy – their sense of duty for their patients should come from within.

Quality Control Issues (QCI)

QCI shows many issues within the hospices scope, such as burnout, understaffing, and aging. Understanding these industry-wide problems contributes to the viewpoint on what impediments we face in 2021. Current data show 50.7 percent of Medicare patients show a date of enrollment in hospice at the time of death, and the Lifelong Length of Stay (LLOS) for Medicare patients enrolled in hospice was 89.6 days, leaving an expectation placed on the management and nurses (NHPCO Facts and Figures, 2020). To begin with, hospice burnout is a significant issue affecting interprofessional teams, as the nature of the job requires both physical and emotional burnout. Between formulating and implementing effective communication strategies, developing patient-centered care plans, and discussing the end-of-life goals with patients, hospice clinicians are bound to experience burnout.

In fact, according to a 2019 study by Net Health, 62% of professional palliative caregivers suffer burnout. One of the ways the hospice system tries to counter this issue is through the integration of diverse health professionals so they can share the task and relieve the burden. Secondly, the rise in the population of older Americans with chronic illnesses has resulted in understaffing of hospice centers. Hospice care is hardly a one-person job, and thus, the input of multiple professionals is mandatory for the provision of quality and efficient care. However, the rise in patients in need of hospice care and the complexity of duties has resulted in understaffing, limiting the effectiveness of the end-of-life care (Nalley, 2021).

Additionally, the ageing of hospice professionals is also a quality control issue as it relates to staff shortages. The ageing staff represents a good portion of the experienced professionals and retiring leaves only a few professionals on the job to match up to the rising number of terminally ill patients. Besides the contribution of aging to understaffing, it is also responsible for burnout as the older professionals find it difficult to tend to their personal needs apart from those of their patients. A lack of success with addressing these problems certainly affects many hospice representatives in their capacity to care for their patients and themselves (Nalley, 2021).

Causation in Burnout

The hospice industry is struggling to keep up with the growing demand for hospice care as nurses withdraw. A lack of control around overtime hours and extensive caseloads and nurses retiring due to burnout is also a problem. Sometimes, these sentiments were there, and not enough new nurses fill the gaps left in these institutions with poor quality of care (Lupu et al., 2018). Burnout can be described as mental, emotional, or physical exhaustion. In hospice care, burnout can be caused by different factors. One of these factors is high demands and expectations from families, patients, and communities. For one, terminally ill patients need assistance at the end of life and are very dependent on their professional caregivers. This means that they must be present to serve the patients regardless of their personal issues. In addition, the transience of life is complicated not only for the dying but also for those assisting them with the transition. On the other hand, families of the dying also depend on these professionals to take care of them and for counseling before and after their loved ones have passed on. More significantly, the work of hospice professionals should encourage community members with terminally ill patients to enroll them in hospice care. Therefore, hospice practitioners are bound to experience physical, mental, or emotional burnout at some point. One way of countering mental and emotional burnout is by enhancing the caregivers' access to psychological counseling (Pavelková & Bužgová, 2015). The less stressed and mentally exhausted they are, the better they are at caring for their patients and, consequently, the higher the patients’ satisfaction. Similarly, assigning hospice staff with practical tasks and schedules and ensuring the ratio of staff matches patients can help prevent physician burnout.

Customer Dissatisfaction

End-of-life care is an unusually emotional time for the patients and families who understand the possible outcomes. Navigating these emotions, satisfying troubled families, and rendering quality care are all responsibilities of hospice staff (Donald, 2016). Hospice is different and comes with challenging emotions from patients. Acting quickly on your feet and being confident in decision-making were qualities needed in the process of hospice care (Tanco & Epner, 2018). Some of the factors that lead to customer dissatisfaction in hospice care include failure to meet patients' end-of-life goals, unmet symptom management needs, lack of respect for the dying patient and their grieving family, poor communication, and lack of emotional support.

Firstly, the main goal of palliative care is to meet the patient's end-of-life goals. This means that anything that disrupts the physical, mental, or emotional comfort of the patient and their dignity is a dissatisfaction. A case in point is aggressive care, whereby the professional continues with the treatment plan sabotaging the patient's comfort by prolonging their suffering. Secondly, unmet symptom management needs are also a cause of customer dissatisfaction. This is because symptom management is one of the ways hospice cares meet the comfort needs of terminally ill patients to ensure that they experience the best final days possible.

Another cause of customer dissatisfaction is a lack of respect for the dying patient and their grieving family. End-of-life care is meant to maintain the dying person's dignity and help them accomplish their end-of-life goals. Failure to do this can be equated to a lack of respect. Similarly, the family's involvement in end-of-life care goals is significant considering how difficult it is to get through the loss of a terminally ill loved one (Stevenson & Sinclair, 2018). Thus, it is the responsibility of hospice staff to guide the family during this time as a show of respect.

Further, poor communication equals customer dissatisfaction. As discussed earlier, communication in palliative care is key between discussing the end-of-life goals with patients, counseling them and their families, and consulting with other professionals. Thus, customer satisfaction is dependent on the effectiveness of the communication strategy. More significantly, lack of emotional support exemplifies customer dissatisfaction seeing that tending to the patients' emotions is a major goal of end-of-life care (Stevenson & Sinclair, 2018).

The Problem

The principal purpose of hospice care is to enhance the welfare of patients facing chronic or life-limiting illness through special care services (Koch & Jones 2018). Central to this function is having a clear-cut model that prioritizes positive patient outcomes by providing compassionate care for people living with life-limiting or chronic illnesses (Lawler et al., 2020). An empirical study about people living with chronic disease in the United States revealed that nearly 45% of American households suffer from at least one chronic disease making it necessary to have programs and facilities to offer quality services to these affected individuals. Globally, chronic illness has adversely affected many people's quality of life, making it a significant driver of health care costs. Other costs include adverse effects on the workforce by reducing the number of people participating in economic activities, thus decreasing overall gross domestic growth and sectoral productivity (Partnership to Fight Chronic Disease, 2021). According to the Centers for Disease Control, the U.S alone accounts for 75% of the aggregate healthcare spending, with an estimated $5300 per person annually (Centers for Disease Control and Prevention, 2021b). The public insurance programs show that chronic illness-limiting illness treatment alone comprises a more significant expenditure. Notably, close to 96 cents per dollar spent on Medicare and 83 cents per dollar Medicaid goes directly to treating chronic illness. As such, getting valuable insight into the role hospice care treatment plays in treating chronic disease contributes to setting a solid foundation for improved productivity in the country (Murray & Thompson, 2021). Besides, understanding the concept of hospice care services will be ideal in setting a solid foundation to reduce mortality rates and enhance better quality healthcare for citizens.

The general problem was management’s failure to provide high-quality hospice care in healthcare facilities, resulting in quality control issues and customer dissatisfaction within the hospice centers. Many agencies do not offer the quality of care that patients deserve, creating management problems, quality of care problems, and dissatisfied patients (Al-Hussami et al., 2017). The health systems in the United States are often not prepared to manage the burden of cancer patients. The large number of cancer patients in the U.S. often do not have access to appropriate quality diagnosis and treatment, creating the phenomenon of failure of quality of care in the management process (World Health Organization, 2021a). According to World Health Organization 2019-2021 research, cancer is the second leading cause of death, accounting for an estimated 9.6 million deaths yearly worldwide. The problem has been of vital interest to healthcare administrators, and researchers have concentrated their applications on finding practical solutions to the problem. These predicaments incorporate management problems and data quality issues. For starters, the fact that many hospices today are now for-profit has made this problem quite extensive. As mentioned earlier, hospices prefer hiring less highly skilled personnel meaning that they are always understaffed and the available staff experience burnout every so often.

Additionally, most of the experienced hires are aged and nearing retirement, threatening further understaffing. These quality control issues compromise the quality of care provided to patients enrolled in hospice care and limit effective outcomes. Additionally, many for-profit hospices prefer to enroll patients for longer terms to accrue more significant profits. Further, in a bid to benefit from the profits, these hospices limit the services provided to terminally ill patients so as not to incur high costs.

Management designs within hospice care are a fundamental element of high-quality hospice care. Scholars have explored the intermediary management guides across comprehensive points for independent (for-profit) vs. dependent (nonprofit) hospice facilities (Boros, 2021). Findings show that the independent hospice facilities had significantly fewer full-time registered nurses and had a relationship with more irregular social worker full-time employees as a proportion of psychosocial staff. Furthermore, there were also fewer clinician full-time workers in the janitorial sector of the hospice centers (Haugland, & Reime, 2020; Hawks, 2019). On the contrary, their nonprofit counterparts have more professionals working around the clock to aid dying patients with the transience of life. In addition, they provide a variety of services and even do home visits for patients under hospice in the home environment.

This study did not address the dependent vs. independent concept. Rather, it used the Chi Test determination to support the literature review and the concepts. Scholars' observations suggest that dependent hospice centers or public hospitals have the staff, nurses, and physicians to support a better Quality of Life (QOL), resulting in better quality control and customer satisfaction among cancer patients. These observations suggest that ownership representation may have a significant correlation, but more organizations are aimed at overall hospice healthcare. For this reason, this study focused on Quality and Outcomes Framework (QOF), Quality Control Issues (QCI), and leadership theories to try to address quality control issues and customer dissatisfaction among cancer patients.

Management’s Failure to Provide High-Quality Hospice Care

Frezza (2019) stated that all cancer care centers must promote collaboration among healthcare professionals, patients, and family members or caregivers to avoid management failures. Due to complex and often implied conceptualizations, the lack of management application suggests that the full range of potential circumstances calls for a model connecting policy to practice—these models range from employing leadership theory and Maslow’s theory of motivation. Jin et al. (2020) defined a set of office tools to address physician, patient, and management barriers. This study evaluated the effect of using more conventional management to deliver better clinical practices—one of the areas that demanded the study's keen interest in developing effective interventions to address burnout. Secondly, the study also looked into how to get similar results across all hospices, whether for-profit or nonprofit, including patients' access to quality services to manage the failure caused by the management. Moreover, the study aimed to find ways that customer satisfaction for both dying patients and their families can be enhanced since that is the main goal of hospice care.

Bormann and Rowold (2018) documented distress between patients and nurses and examined managerial or organizational predictive roles in constructing leadership style. For example, colleagues' self-sacrifice approaches toward others offer an exchange between leadership support and employee behavior. This research confirmed the information gap and focused on examining decision-making process factors, developing experience with, and understanding of those circumstances, and improving policy-making decisions. Some of the areas that the study looked at in-depth were as follows:

Quality Control Issues. Quality control issues are extensive in hospice care, starting with the quality of services and resources and meeting patient needs. Singh et al. 2019a show that data analysis infers that utilizing the Quality Improvement (QI) strategy in palliative and hospice care improves the quality of care given for patients and can enhance patient fulfillment.

The Hospice Staff. The hospice staff operated well collectively to administer care to the hospice patient (Measuring the Quality of Hospice Care, 2016) – the need for collaborative input from the interprofessional team is key to addressing quality control issues, and thus, the study assessed the various ways that can be used to achieve progress.

Bates' (2009) model is a practice foundation used by The Joint Commission for patient treatments. These standards also guide hospice standards in the industry. This model is being practiced strengthening health center practice, evaluate public health nursing, education, and management. The ultimate mission of The Joint Commission's accreditation program is to improve the quality of care and patient safety. These essential guides also set standards for the average number of visits to a patient per week, nurses process, hospices staff, home health aides, social services process, and the quality of data collected. (Measuring the Quality of Hospice Care, 2016).

Bates' guide to physical examination and history more or less goes into the same principle in internal medicine-pediatrics and is still present today. At the same time, Bates notes the rarity of experienced mentors and role models as necessary to the quality and training (Bates 2009).

Data Quality Issues. Most companies say that data quality issues are identified when reported by workers. Fewer than one in two organizations conduct proactive data audits to identify data quality issues and lead to management failure most of the time (Bates, 2009). Data quality is necessary for the process of management in a hospice center. However, it also helps guard against common pitfalls, for example, advertising disclosure and patient disclosure.

Concepts

There is a necessity to enhance access to hospice care management for cancer patients' quality of life experience (QOL). Connecting the inputs and how they correlate with the Intermediary variable (Leadership Management), actors (Hospice Clients), and other variables (independent, dependent). This study employed motivational theory and leadership theory to assess management style differences between independent (for profit) and dependent (nonprofit) hospice centers.

The Chi-squared Test of Independence is an idea set by author White (2016) that shows realistic approval to patient flow by analyzing the relationship between variables. The chi-squared was represented in Figure 1, by variable, theories, and symbol as $\chi 2$ (where χ denotes the

Greek character chi). This research processed the mathematical test for relationships between categorical variables and actors and theory. Leadership management style can give specifications to design and style. Leadership theory concentrates on the traits and behaviors that people can adopt to increase their leadership capabilities (Ventegodt et al., 2003).

Intermediary (Leadership Management)

Services provided by hospice leadership also represent intermediary services that offer a wide range. This is defined by the World Health Organization (World Health Organization, 2021b). To improve the quality of care, hospice administrators must be willing to change organizational developments that are likely to enhance the intermediary quality of input for better performance and improved patient results. The leadership standards must prioritize the need to encourage and motivate. Most noteworthy, the management model should focus on enhancing optimal quality services to deserving patients instead of profiteering. By focusing on the welfare of the patients, the management model in the care facilities will be geared toward improving the hospice care with the desired optimal concerns (Giammalva et al., 2018). Besides, it will be instrumental in working toward improving society's healthcare outcomes. The objective was in line with Maslow's hierarchy of needs. Notably, the model emphasized the support for Maslow's theory: physiological needs, safety needs, love, belonging needs, esteem needs, and self-actualization needs. Under this concept, health provision will be crucial to ensure that individuals are in the right psychological state (Noltemeyer et al., 2021). A significant number of patients suffering from chronic or life-limiting illnesses often suffer from psychological conditions that have adversely affected their wellness. By having a model that aligns with quality healthcare provision, hospice care services will be instrumental toward setting the foundation for the health management hierarchy of needs (Ventegodt et al., 2003). Patient satisfaction significantly affects mental and physical health (ASCO, 2016). Many patients do not feel satisfied with their care, especially at the end of their lives (ASCO, 2016).

Leadership management in the hospice care units immensely determines the outcome of the services offered. Having a staff that is fit for the executive position is seen as the influencer of the performance of the subordinate and is also cost-effective (Drennan & Wittenauer, 1987, p.29). Nurses are supposed to have self-esteem as it is believed that nurses in many facilities give the patients hope; thus, sharing esteem with patients is among the qualities essential for the care in these units. Therefore, the nurses require support from the officials so that they can manage to offer these essential services to their patients and their families (Drennan & Wittenauer, 1987, p.30). Similar ideas are shared by other research arguing that officials determine the Hospice industry, and the executive is supposed to be highly skilled for developing the Hospice care industries (Longenecker, 2006, p.206). In the management of the day-to-day activities, the executive is supposed to be sensitive to the nurses as it is believed the nurses will pass the same concern and sensitivity to the patients to attain the target of the day, which is to offer the patient appropriate and quality healthcare in their last days (Drennan & Wittenauer, 1987, p.30). The management is also mandated to ensure satisfied staff members avoid inconveniences such as absenteeism and resigning at the most crucial moments of the Hospice operations.

A good management team has the duty of preventing this as it is costly by ensuring policies that favor all the staff members to ensure continuity of the industry as it involves a continuous process of marinating patients in their last days. Furthermore, leadership in the hospice sectors is also of interest due to the changing dynamics of the world, thus affecting the old regime of administrators in these units; a change to incorporate young and new leaders in the system is the central aspect of change in the units to ensure the system is adapted to the changing global dynamics (Longenecker, 2006, p.206). Thus, the leaders in a hospice determine the outcome of the performance of all the staff members as they are in charge of making policies that create enthusiasm within the institution that creates better performance in practicing hospice treatment.

Concentrating on a leadership development plan intensifies the qualities and aspirations to turn into a reality. Each potential is limitless and investing in personal development is a way to harness talents. Establishing intentions and purposes for what leadership wants to achieve is essential, where the organization wants to go in the short term or long term can improve hospice planning (Hinojosa, 2019).

Kerin and Hartley (2019) discuss selling and how leadership needs to sell everyone, and everyone working in an organization is selling something. This is especially true for manufacturing sales organizations, real estate brokers, stockbrokers, and salesclerks who operate in retail markets. Nevertheless, every occupation that connects customer contact has an ingredient of personal selling. For example, attorneys, accountants, bankers, and business organization recruiters perform sales-related activities, whether they recognize it, but this is especially true in the hospice industry.

Researchers showed that each one of us has a predisposition to generate customer value in our genes. Are you a born salesperson? Michigan Marketing Professor Richard P. Bagozzi offers a novel insight into this question. Their study recognizes a genetic marker, the 7R variant of the DRD4 gene, which is associated with a salesperson's predisposition or willingness to communicate with customers and learn about their problems to meet their needs (White, 2016). The researchers also found that the A1 variant of the DRD2 gene correlates with a predisposition or tendency to persuade customers to buy a given product rather than listen to their needs. These two different genetic markers help explain the difference between leadership, salesperson, and customer orientation versus sales orientation (nurse). Faced with a selling situation, do you have a sales orientation or a customer orientation? Kerin and Hartley's (2019) questions posited that sales orientation (SO) requires persuasion and selling to consumers. In contrast, customer orientation (CO) is more about interacting with and encouraging patients to talk about their difficulties so that the nurses can understand their demands (a method akin to co-creation of solutions) and leading them in touch with answers to their problems. Seldom has an idea sparked so much interest, resonated with both researchers and practitioners and given such a good plan for leadership planning within the hospice network (Carraher et al., 2009).

Theories

Maslow's Theory and Leadership Management Theory elucidated the concept of a hospice system composed of independent agents or parts that interact interdependently by supplanting principles to establish patterns that influence the end of life. QOL was the phenomenal concept of this study. Maslow's motivational theory addressed the need to meet quality control and pivotal needs, such as physiological needs and safety needs, to reduce anxiety during symptoms and suppress pain (Dohlman et al., 2019; Hinojosa, 2019).

Maslow's Theory

Maslow's hierarchy of needs theory can motivate nurses in hospice units: the theory revolves around a pyramid of human wants from the least to the highest that an individual can attain at a single moment. People's needs at the minor level must be satisfied before upgrading to the next level of needs (Fisher, 2009, p.350). This can be helpful to executives. If they comprehend the level of wants of every employee in the institution and understand what type of motivation is used in every stage of wants, they will use it to improve their staff (Fisher, 2009, p.350). These levels of needs by Maslow are the best foundation for motivating an employee; if the executive comprehends the needs of the nurses, they maintain them as unfulfilled because if they are met, they cease being motivation again. However, in other studies, it is essential to ensure the needs of the employees are met at the lower levels to make them comfortable in their services to the company (Latting, 1991, p.52).

Leadership Management Theory

These components of leadership theory related to the hypothesis and demonstration of the relationship rather than variables. Meltzer and Schwartz (2018) demonstrated that policy implementation indicators often measure activities or fulfillment elements of the policy implementation. The leadership management theories emphasized the critical role played by leadership in changing the behaviors that individuals adopt in service delivery. Central to the leadership management theory is improved outcomes in an organization's setting. It minimizes the risks of failure in an organization while setting a solid foundation for optimal health outcomes.

The unique management model should focus on enhancing optimal quality services to deserving patients instead of profiteering. By focusing on the welfare of the patients, the management model in the care facilities will be geared toward improving hospice care with the desired optimal concerns (Sobanski et al., 2020). Besides, it will be instrumental in working toward improving society's healthcare outcomes. Under this management leadership concept, health provision will be a key priority to ensure that individuals are in the right psychological state (Łukowski, 2017). A significant number of patients suffering from chronic or life-limiting illnesses often suffer from psychological conditions that have adversely affected their wellness. By having a model that aligns with quality healthcare provision, hospice care services will be instrumental in setting the foundation for Maslow's hierarchy of needs. Examples could incorporate:

Organizations' Written Policies. Having policies articulated in the organization will be ideal in sensitizing the employees to achieve the desired optimal productivity in care service delivery. Most noteworthy, written policies act as a reminder of the need to stay focused on the objectives and goals of the organization of meeting the needs of the patients and enhancing optimal wellness for all. Management should always ensure that all the policies are written and articulated for ease of implementation (Selman et al., 2018).

Adjudication. Adjudication is also another equally important element that should be aligned to the organization's management strategy to achieve the desired outcomes. The adjudication element in management can be succinctly implemented by having procedural management and managing the evidence when handling patients. Adhering to the set care procedures and proper evidence handling record keeping will be ideal for enhancing the desired patient outcomes (Slater, 2020).

Effectiveness of Training Materials. Effective training is also instrumental in enhancing optimal productivity in society. Training equips the staff with the appropriate skill set required to handle patients and adhere to the set regulations in the healthcare sector. Periodic training also enlightens the team about the emerging treatment measures that improve patient outcomes (Claxton-Oldfield et al., 2020).

Awareness of policy. Awareness creation is instrumental in encouraging the staff to achieve the set objectives of optimal patient outcomes. Besides, awareness creation of the formulated policies helps nurture a culture of responsiveness that is instrumental in developing the foundation for better service delivery for all (Hakola,2019).

Survey of Compliance. Getting accurate insight into the compliance levels of the set policies also guides the management on the ideal strategy to adopt to achieve the desired outcomes. Notably, the survey will be suitable in showing the progress and path taken by various staff members to adhere to the policies within the organization (Kneuss et al.,2019).

Among the relevant leadership management theories is the transformational leadership theory. The theory offers valuable insight into the instrumental role played by leadership to set an organization on the path to success by transforming the attitudes of its workers. In the context of hospice care services, transformational leadership will be ideal in instilling the appropriate attitude to the caregivers, thus enhancing improved service delivery to all people (Cassel et al., 2021). Besides transformational leadership approach will be ideal in aligning the hospice care services with the expected welfare outcomes of the affected patients (Łukowski, 2017). Most noteworthy, transformational leadership theory will be applicable in revealing the need to embrace management models that are in line with the long-run objective of improved patient wellness.

Leadership management theories are structured as the school of thoughts or philosophies that explains how and why some people end up being leaders while others do not; they can thus be used to discuss leadership in the Hospice units and how they and expound on the traits and behaviors that people possess or can attain to increase their strength in leadership positions (Leadership Theories, 2021). Major leadership theories have expounded on this aspect; for instance, The Great Man Theory may propose that best leaders in the hospice units are born and cannot be made in the company. A similar theory is the Leadership Theory that supposes that leaders' effectiveness can be predicted by comparing the potential with those of the current leaders; contingency and situational theories propose that no leadership is better than the others, and this makes it possible to apply a leadership that fits the current situation (Leadership Theories, 2021). This can be applicable in hospice care centers.

Treatment within the health system is the primary care management subsystem for leadership and aspects of leadership operation may require a different kind of leadership to solve the given problem. Seldom with little change and policy, the problem leading to leadership level is sometimes considered unstable; it may also be concurrently ingrained with situation with decision making processes (Dixit & Sambasivan, 2020).

For example, in a different situation, another theory and the fittest theory in healthcare institutions is the behavioral theory that states that leaders become great leaders by having many attained skills. Dixit and Sambasivans' study creates a combined multi-theoretical design of public healthcare services delivery for organizations' leadership. These leadership steps show control over resources, isomorphism, accommodation to changing circumstances, and fundamental elements of the resource dependence on leadership theory (Meier, 2010).

Constructs and Variables

The relationship between actors was developed into a construct measurable pattern in this study. Actors included cancer patients, cancer care professionals, families, and relatives of the patients and acute care departments in the United States. Firstly, cancer patients were the primary actors because hospice treatment is meant for them due to their terminal illness. Secondly, cancer care professionals are responsible for providing hospice care to these cancer patients ensuring they achieve the utmost comfort level. Finally, the role of families in hospice treatment is to provide support to their dying loved one physically, mentally, and emotionally. Family members have a caregiving role, but even those without the family caregiving role are still in need of it significant at the end-of-life. In the past, the lack of clear policy and improper process may have contributed to high turnover with lack of commitment and satisfaction among personnel (Dohlman et al., 2019; Bally et al., 2019). Other constructs used in this study to assess the hospice patient’s experience included satisfaction, happiness, and comfort. The constructs that investigated inpatient experience looked into the quality care offered during treatment (Beattie et al., 2015). The satisfaction construct was measured by the willingness of the patients to stay in the healthcare facilities to receive hospice care services. Notably, a high willingness from the patients reveals that they are pleased upholding the need of the services to other patients. Satisfaction can also be measured by the desire of the discharged patients to visit the healthcare services for similar hospice care services should their conditions recur (Selman et al., 2018). The number of referrals can also measure it from the discharged patients to the healthcare facilities. On the other hand, happiness may be measured by the feedback left by the patients in the different care centers offering hospice care services. The quality of services can be based on the patients' feedback during and after the hospice service delivery in the healthcare facilities. Having an optimal performance level of the three constructs will be ideal in setting a solid foundation toward achieving the desired healthcare outcomes. Similarly, this is the main construct used in hospice care units. The quality of care is based on how satisfying the care was, that is, how satisfied and happy the patients are with the hospice care provided to them (Hu et al., 2019). This makes the abstract constructs in the research to be comfort, joy, and satisfaction.

This research incorporated three types of variables: independent, intermediary, and dependent variables. Creswell (2014) postulated the independent variables, intermediary variables, and dependent variables as uncertainties that determine the direction of the study. These variables are influenced by the constructs used in the research. An excellent example of an independent variable used in the research includes the patient's age, where age is regarded to indirectly affect the outcome of the customer's satisfaction (Holland et al., 2015, p.6). Age can be used in the study to increase the comprehensiveness of the data gained from the research, but it cannot affect the patient’s experience, or the services offered. Another independent variable is the private centers used in the hospice care centers. Hospice care refers to the services rendered to dying patients towards the end of life. If executed correctly, hospice care can enhance the quality of care, thus enhancing customer satisfaction.

An intermediary variable in the study was the patient and their family's information regarding the services (Holland et al., 2015, p.7). It is assumed to have psychological effects on the patient where misinformation about the services may affect the patient's satisfaction after spending some time in the facility and realize the difference between the promised services and the services being offered. Another intermediary variable was leadership management that focuses on management patterns across nonprofit and for-profit hospices. According to research, the difference in managing these two types of hospices causes a variation in quality care outcomes. Management patterns across for-profit hospices show that their operation is guided by potential profits that can be earned, while nonprofit ones are concerned with satisfying their patient's end-of-life goals. Lastly, an example of a dependent variable used in the assessment of hospice patient experience was clinical efficiency. This was seen as a dependent variable because numerous studies have concluded that it is positively related to a good patient experience (Jha et al., 2017, p.36; Latting, 1991). In the research, a patient’s experience was related to the effectiveness of the clinic to deliver services in the hospice units, thus making it a dependable variable. In addition, the quality of care given to patients under hospice programs is a dependent variable because it relies on the efficacy of the services provided to these patients and the way they are delivered. For instance, in for-profit hospices, the quality of patient care is often low because the services rendered are minimized to avoid incurring high costs that may eat into profits. On the other hand, the quality of patient care in nonprofit hospices is better because the care professionals and the management are not swayed by money.

Related Studies

Management patterns within the hospice care industry are a vital element of high-quality care (Williamson et al., 2020). Various scholars have sought to investigate intermediary patterns across dependent (nonprofit) and independent (for-profit) hospices (Wouters et al., 2018). Findings reveal that independent (for-profit) had significantly less staff in place at all cross-sections (World Health Organization, 2018). Such prognoses present a complex problem and further related study. These observations suggest that ownership type leads to significantly better management. The main argument addresses whether management performance conditions and opinions vary based on providing better quality. The following principal addresses the current literature on hospice management: personal work participation, hours worked, view on hospice groups, and patients' responsibility. Expanding knowledge on these topics will improve understanding of how the intermediary changes patterns for hospice leadership.

Empirical research of chronic illness in the United States by Wullianallur and Raghupathi offers valuable insight into the ideal ways of providing care services to patients with life-limiting diseases (Raghupathi & Raghupathi, 2018). The research explored the current state of chronic illness in the United States with insight into the possible adverse effects it has on society and the ideal ways of dealing with the problem. Using data from the Center for Disease Control and Prevention, the study revealed that chronic illness requires optimal quality care services to achieve optimal productivity. The study focused on different correlational variables like chronic disease conditions, behavioral health, mental health, demographics, and overarching conditions to unearth the variations in life-limiting illness prevalence and the country's mortality rates. Insight from the study shows design appropriate care delivery services to set a solid foundation for improved wellness of the affected patients. The study is related to this one as its primary focus is identifying the appropriate care services that will help improve patients' health with chronic or life-threatening illnesses. By acknowledging the role of government and other non-governmental organizations in controlling the adverse effects of chronic disease, the study aligns with the purpose herein unraveling the ideal ways of using hospice care services stoa optimal chive wellness of the vulnerable individuals in the society.

Independent Problem with Staffing

Independent hospices experience understaffing because they hire fewer personnel with high expertise (Viftrup et al, 2021). Thus, while the personnel are well skilled in hospice care, they are outnumbered by the patients in need of their care. This makes it an important topic to conduct further research on.

Hospice Management Personal Work Participation

The management of independent and dependent hospices is also a worthwhile topic to study. The angle that can be taken with this study is personal work participation between the two types of hospices and their impact on the quality of outcomes (Williamson et al., 2020).

Hours Worked. The number of hours worked can explain the quality of patient outcomes for hospice care. Additionally, since burnout is such a common issue in hospice care, studying hours worked across hospices can help determine the extensiveness of burnout among hospice care professionals (Viftrup et al, 2021).

View on Hospice Groups from The Study

There are a variety of hospice groups, including home hospice care, making this a viable study direction for a better understanding of hospice leadership (Meier et al., 2010). Hospice is a unique care model for patients in the late stage of a severe illness and who wish to receive end-of-life care at home or in a specialized care environment. A significant priority of hospice is to incorporate the principles of hospice care to decrease anxiety and distress in the face of an advanced or terminal illness (Williamson et al., 2020).

Patients' Responsibility

For effectiveness in hospice care, the patient's input is critical. Their decisions on what they want their end of life to look like determine the next step for care professionals. It is essential for management to allow patients to create their end-of-life goals for utmost satisfaction to be accomplished (Drennan & Wittenauer, 1976).

Another topic of interest in hospice care assessment in the United States is the positive effects of hospice care given for an extended period over hospice care given over a short period. Research shows that patients who receive hospice care for more extended periods are likely to gain more end-of-life patient satisfaction (Heath, 2021). Hospice care gives the individual a high-quality life, thus making accurate their death wish and offering a satisfying death. However, the advantages of hospice care depend on the duration upon which they were introduced or upon the treatment session of the person. For instance, cancer patients usually experience painful endings as they near their deaths. Therefore, hospice care relieves them of the pain as they offer an optional model of care that focuses on reducing suffering. This can occur at their homes, thus evading the medical environment in clinics (Heath, 2021). The length of the stay of the services has been proven to have positive benefits upon the patient; this was done via interviews with the families of the deceased because of cancer randomly, where half of the samples were under the care while the other half was not. Half of them under the care proved that their family members had a better end-life than those who did not; they added that their ailing folks were offered some medicines that aided them in managing pain and suffering (Heath, 2021). This topic of interest calls for the need to create mass awareness of the importance of signing their patients with the program before the disease accelerates to ensure that the family members receive hospice care early enough to prolong the quality of their end life care. This can also aid the family in saving finances as they withdraw their funding early, sufficient as a sign of despair of getting treatment for their sick member.

Further, the anticipated theme was to get valuable insight into the positive outcome of the patients who have received hospice care services. The insight of the patients' outcome was instrumental in informing the policy formulation in the public healthcare programs. Should the feedback be positive, the government and other non-governmental entities will be willing to increase resource allocation to aid the provision of hospice care services, thus continuously improving the wellness of the patients with life-limiting illnesses (Raghupathi, & Raghupathi, 2018). Further, a positive outcome encourages the government to increase resource allocation in the healthcare programs as a way of easing pressure from the would-be increased demand for these services. By increasing the resource allocation to the provision of this essential service, the patients' outcomes will significantly increase, setting the foundation for optimal productivity in U.S. society.

Physiological Safety to Reduce Anxiety During Treatment Symptoms of Pain

Physiological safety to reduce anxiety incorporates massage therapy in many hospice centers. The most robust research evidence for the benefits of massage is stress and anxiety decrease, although studies for pain control and management of other symptoms traditional to patients with cancer, including pain, are encouraging and works (Buchbinder & Shanks, 2021). Future healthcare endeavors should concentrate on the organization's teamwork to better help physiological safety; this is an essential part of the hospice workforce that is better topographically disseminated and prepared to give socially skilled consideration to different populaces.

Since 1979, the U.S. healthcare system has attempted a series of team-building concepts, over ten-year plans illustrating key national well-being targets, called Solid Individuals (Shi & Singh, 2019). The objectives for these projects depended on the combination of therapeutic consideration with deterrent administrations, well-being advancement incorporating individual and network well-being (Shi & Singh, 2019). In recent decades, the number of point centers and goals has consistently developed, in any event significantly increasing in size since 1990. The model of Solid Individuals' broader objectives includes: to accomplish high caliber of lives, free from preventable infections, accomplish well-being value, and make social and physical conditions that advance great well-being, advance, or nature of life, and improvement (Shi & Singh, 2019). These measures are general well-being pointers for personal satisfaction, determinants, and differences among the populace (Shi & Singh, 2019). Understanding the current and anticipated medicinal services issues implies stretching beyond human services concerns.

Reducing anxiety consolidating massage therapy also helps administration and enables discovery. For example, the Affordable Care Act (ACA) has helped over 20 million with insurance coverage and access, distinguishing what necessities are needed, expanding range and training. Leadership management theory plays a significant role in this study in addressing the central concept of patient satisfaction and the different variables of the study (McRae, 2017).

Daher et al. (2018) have posited that the leadership strategy is based on the proposition that leadership effectiveness is maximized when leaders accurately make their behaviors contingent on specific situational and follower characteristics.

Anticipated and Discovered Themes

The findings in the Quality and Outcomes Framework (QOF) design for management added to the existing literature on hospice representatives and leadership: individual work experience, perspective on hospice organizations, and patients' responsibility. Expanding knowledge on these topics will improve understanding of the shift from QOF to management responsibility and improve hospice workers' skills and quality of care (Johnston et al., 2020; Meier et al., 2010).

The anticipated and discovered themes in this study were the issue of funding the hospice care in public health sectors, and the issue of programs for the general public that would aid in educating the population the benefits of the hospice care system in the lives of people living with chronic illnesses and their families as well. The funding of hospice care is a theme of interest because studies argue that many people are not even aware that they had the chance to subject their loved ones to these services as the funding is catered for in the Medicare program; Medicare is offered to people with low incomes (Davis, 2016). The Medicare hospice benefit was endorsed in 1982 by congress covering more than 85 % of the citizens under the program. The services covered by Medicare for hospice care include doctor services, nursing, medical equipment inclusive of wheelchairs, counseling, grief and loss counseling, and medications (Davis, 2016). This ensures that the patient is fully covered in their last days of life without the family struggling with the hospital bills and the cost of hospice care. It is a topic of interest because many people do not understand their rights to access these funds; thus, due to a lack of insight they subject their patients to the system when it is too late.

Another interesting and exciting theme was creating awareness of the availability of the care systems and the rights of people to attain them under the constitution mandated by congress. This is because of the discussed issue in the study that people are not aware that their loved ones can access hospice care as catered for by the government via Medicare. Studies show that many people only regret later introducing their dying family members to accord them quality care during their last days (Davis, 2016). This could be introduced in the curriculum or social media platforms to hold campaigns to educate the public on the system. Also, including the benefits of hospice care to patients with chronic disease to the campaigns would make many people get insight into it and thus enroll it, thus making the program effective as it is supposed to be.

Summary of The Literature Review

The pros and cons of entering hospice care can vary depending on individual needs and circumstances. Regrettably, many patients are not referred to hospice care by nurses, doctors, and administrators until it is too late, resulting in the patients’ end of life. Due to misconceptions and a general lack of knowledge of its advantages and services, many patients fail to enter hospice at all. This leads to the underutilization of this functional form of medical care and a failure to fulfill cancer patients' wishes at the end of their lives. Conclusively, this research has served the purpose of assessing and thoroughly elaborating the hospice care treatment patient experience and how they fulfill the desire for a satisfactory death. The introduction of the actual concept of hospice care treatment is described as the most quality care given to victims of chronic diseases, and it is above the standards of the usual treatment offered in that specific institution. Further, the study reviewed the leadership process in the hospice industry and how it influences efficiency in administering services to chronically ill patients. The management in the industry is related to leadership theories expounding mostly on Maslow's theory where there is a discussion of the hierarchies of wants by Maslow creating a platform for the management to understand the actual motivators of the employees and used them for the advantage of the company in its obligations. Further, the review explored the constructs and variables used in the research to assess hospice care and establishes the constructs as comfort -which translates to joy and inspires satisfaction in the last days of the ailing person – cancer care patients, their families, and care professionals.

On the other hand, the variables were categorized as independent variables being the age of the person, which do not affect the outcome of the research; intermediary variables as the information that the clinic provided to the patient, as it may affect the outcome indirectly; and the effectiveness of the clinic as a dependent variable, which can influence the experience of the patient they're his family. The study further investigated related topics of hospice care, establishing the longevity of the care as a factor that influences the patient's satisfaction and thus its effectiveness, more extended care leads to a final quality life of the patient. The review delved into discoveries that arose from the assessment of the hospice care, including financing of the programs; the conclusion is that the funding of the programs is catered for by the patient’s Medicare or Medicaid, which is a mandatory and a right to the individual. It also discusses public awareness of the importance of these cares to chronic ill patients via campaigns to ensure that the people take advantage of the programs to help their sick families and save their finances on unattainable treatment.

Transition and Summary of Section 1

The mixed-method study explored the decision-making process behind implementing management in hospice centers within the United States. The study focused on quality of care and leadership management to deliver the best quality of care to patients. Section 1 comprises the foundation of this study, including the purpose and problem statement, which presented the fundamental doctrine of the research. Section 1 further comprises the nature of the study, the research questions, and the conceptual frameworks applied to lead the investigation. Other areas within the study also focused on the significance of the study, biblical integration, and its relationship to health management study. Section 1 concluded with a review of academic literature that addressed Maslow's Theory, Leadership Management, healthcare advantages/disadvantages, understanding the complicated hospice healthcare services, and management's failure to provide high-quality hospice care. The role of management in hospice centers is critical, and what subsists now is the need to leverage management arrangements to enhance the industry. This study concentrated on understanding hospice care's quality and determined whether patients' experiences can be improved through better management in hospitals in the United States.

In addition, this research included interviews with families, patients, staff, and stakeholders who have had experience with hospice care and family members who lost families members to cancer between 2010 and 2021. The discussion and survey questions targeted hospice management facilities, quality of life, and assessed fulfillment of the patients' end-of-life wishes. The researcher investigated a group of 96 patients to meet the mission of the research. The full range of potential circumstances called for a design connecting policy to practice supporting this approach—these designs varied from employing leadership theory and Maslow's theory. Organizations must address crucial elements such as knowledge, individual skills, management arrangements, and communications methods. Organizations must also specify that their mission is defined, designed, managed, and communicated to stakeholders. Doing so will give similar results across all hospices centers, whether for-profit or nonprofit, including the patients' path to quality services to management’s failure to provide high quality hospice care.

The mixed-method study allowed defining how the quality of care can be implemented and the techniques needed to improve future outcomes. Further, the predictable question was to get helpful insight into the positive development of the patients who have experienced hospice care services. The research question filled a knowledge gap in the next section of the research and added to the existing body of literature through discussions concerning the quality of care, the circumstances that affect the development of the quality of care in the hospice setting, and how quality can be improved.

Understanding the patients' outcomes contributes to the future of the study. In turn, it can help in informing the policy formulation in the public healthcare plans. Further, a positive result inspires hospice centers to enhance resource allocation in the healthcare programs to ease pressure from the increased demand for these services. By developing the resource allocation to this essential service, the patients' outcomes will significantly increase, setting the foundation for optimal productivity in the U.S. community.

Section 2: The Project

Section 2 provided an in-depth summary of this project, beginning with the purpose statement and the role of the researcher, including ethical considerations in the study. Next was an in-depth summary of the methodology, an outline of the study’s mixed-method design, and a detailed discussion of the suitability of the research design and method. Following that, Section 2 reviewed the process of obtaining participants, including techniques of securing informed consent, protecting participants, and preserving their anonymity. An examination of the sampled population and sampling methods came next. Data comprised the next sections of analysis, including the data collection method, a review of the data organization procedures, and the process of data analysis. Finally, there was a discussion on how the researcher ensured the reliability and validity of the study.

Purpose Statement

The purpose of this mixed-method study was to address the failure of management to provide high-quality cancer care in hospice healthcare facilities in the United States, resulting in quality control issues and customer dissatisfaction among cancer patients (Marzal-Alfaro et al., 2020; Tandon et al., 2021). The research identified the driving determinants in management designs and causes of burnout and included a literature review in leadership theory.

The intricate reasons for the failure of quality of care in the hospice industry were considered through an in-depth study of the employees, patients, and stakeholders. This is crucial for nurses and physicians who can assist patients with constant care. It is equally necessary for end-of-life care that considers patient requirements on multiple levels (Hall, 2020). According to Best (2020), quality care that addresses the patient's needs results in satisfaction and increases the quality of the patient's life. The research questions in this project filled a knowledge gap and added to the existing body of literature through discussions concerning the quality of care, the factors that impacted the preparation of the quality of care in the hospice environment, and how quality can be improved.

Role of the Researcher

This section discusses the role of the researcher in this study. The first critical role of the researcher was to conduct an appropriate analysis, which means determining the process of the output of the analysis and addressing the research questions and objectives through the study's multiple phases.

A second critical role was to adhere to the ethical principles drafted by research guidelines, like the Belmont Report and those of the Liberty University School of Business and Health Management (Moore, 2021; Bist, 2014). The Belmont Report lays out the basic ethical principles to protect human participants in research studies, as identified by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (2021). Some procedures described in the Belmont Report introduce respect for human subjects and obtaining informed consent. The researcher assured adherence to the Belmont standards and the principles of ethics during data acquisition (The Belmont Report, 2021).

The researcher remained employed with the Research Institution, which is a health provider organization, and because the Research Institution is a licensed federal health organization, all federal and local laws are followed. These laws also provided regulations and guidance under the Office for Human Research Protections (OHRP), which has published a description of the procedure and regulatory materials to support researchers in complying with ethical research conduct (Office for Human Research Protections, 2021). The researcher maintained an inventory of participant names based on access given by the Research Institution for this research. The Institutional Review Board (IRB) guidelines, the Research Institution organization policies, and Liberty University doctoral requirements converged to meet the standard of ethics for this study. These rules also are set by the federal policies established by national legislation. For example, the HHS regulations for protecting human subjects in research for 45CFR include five subparts and standard rules, which provide a robust set of administrative process standards (Office for Human Research Protections, 2021).

The researcher was responsible for participant recruitment, including initial contact through phone, email, U.S. mail, face-to-face, or internet (Bist, 2014). Before this study, the researcher did not maintain a special relationship with the participants. The researcher used medical records through the Research Institution organization to obtain a list of hospice patients and will secure permission from Research Institution and patients beforehand (Research Institution, 2021). Confidentiality was addressed throughout research preparation (i.e., gathering, analyzing data, securing approval from ethics review boards) and data collection. Upon conclusion of the research, there will be no ongoing individual or business relationship with the participants.

The researcher offered incentives for participation in this study in a fifty dollars Amazon e-gift card. The Research Institution organization allocated the funds for the research. This was essential in recruiting participants, motivating participants, and attaining a large number of returns (Buchheit et al., 2018). The research problem also motivated participants in this study to share their experiences since these were existing patients through Research Institution medical records. The research process adhered to the highest ethical standards following the Belmont guidelines and reduced the possibility of bias due to the variable quality of participant interactions (Buchheit et al., 2018). Raposo et al. (2021) states theoretical justification for applying monetary incentives and the conditions under which they are hypothesized to be especially useful. They found that incentives affect response rates in a mixed-method design and influence more and quicker responses, eliminating nonresponse error and increasing cost-effectiveness Thus, incentives offered aided in the justification, identification of participants, and left out the individual personal view when trying to recruit participants.

Bias in the study pertains to unfairness and influences the results of the investigation. Sampling bias can include asking leading questions and can flow into different phases in the study (Higgins et al., 2019). Therefore, researchers needed to be aware of any opportunities to limit or exclude bias from the study. Whether deliberate or not, prejudice can negatively influence the investigation results, making results irrelevant and insignificant (Munafò et al., 2018). This study focused on eliminating bias of the researcher by following all standards and Belmont Report recommendations. In this study, the research method included surveying other participants from different hospice centers across the United States, helping eliminate biases relating to the participants’ and researcher's roots.

The researcher avoided bias by not shaping participants' ideas or experiences (Munafò et al., 2018). The research aimed to reveal the truth. Any deviation from reality is biased (Higgins et al., 2019). Adding deliberate bias is immoral, unethical, and against scientific standards (Savović et al., 2018). Bias, however, can be interjected unintentionally in the research (Hébert et al., 2016). Unintentional bias is also uniformly illegal, corrupt, and wrong. The researcher was aware of the chances of bias and how to circumvent them. During this research project, the researcher maintained a record and document notes on each participant. Also, the researcher was aware of individual experiences and views regarding the application of medical records which could interject bias and influence the representation gathered. Xue and Desmet (2019) referred to this process as introspection, a means of observing oneself and ones analyzing process or research.

Sawhney et al. (2018) described using introspection as a planned process of self-reflection, allowing the researcher to take accountability for individual awareness such as expertise and opinions. The authors mentioned the spontaneous and introspective experience approach that focuses on co-researchers, allowing researchers to leverage the research process. Researchers have a crucial responsibility to be careful. Uştuk and Çomoğlu (2021) identified the primary importance of applying introspection to keep clarity and develop a means to assure the validity of findings. Such familiarization with the context of research provides introspective insights concerning the method in the research process; self-reflection naturally leads to feeling more knowledgeable.

Introspection is essential for both the means of research and checking the individual self. This process of introspection was also administered to the data collection, literature review, and analysis process. By contrast, in addition to autobiographical data, the researcher's process of introspection was subjected to the acquisition, analysis, and exhibition of all kinds of data collection (Higgins et al., 2019)

Discussion on Bracketing

Bracketing is essential in avoiding personal biases (Munafò et al., 2018). Bracketing helps and holds those study elements that determine the boundaries of the study experience (Qutoshi, 2018). There are various strategies in understanding the process of bracketing in a study. Freeman (2011) attested that understanding and conceiving the fixed meaning of a study gives a purpose in generating and molding the process of bracketing a study. Ray (1985) presents the most practical implementation for qualitative and quantitative approaches, unique to the phenomenological procedure. The author shows that bracketing illustrates the data collection and analysis process within a study design. Recently published phenomenological studies involving hospice care patients show that bracketing supports the validity of the phenomenological research process (Bagnasco et al., 2021). Although bracketing demonstrates the truth of the data collection and analysis process in most phenomenological studies, the researchers' method in practice will be explicit. The process of bracketing must be applied as a process to thwart biases and assumptions to explain a phenomenon. Bracketing highlights the importance of entering the process throughout the data collection, collectively dispensing it as an ethical passageway (Higgins et al., 2019).

Bracketing was used in the qualitative portion of this study to mitigate the possible adverse effects of presumptions that may unduly flaw the outcome data from the research process (Higgins et al., 2019). The participants' experiences in hospice centers helped identify the phenomenology philosophical concept that there is a need for more reliable quality care for the management process (Munafò et al., 2018).

Research Methodology

This research utilized a mixed-method design, specifically, a convergent parallel study design, using qualitative and quantitative procedures. In recent years, there has been an increase in interest in breaking down qualitative and quantitative study distinctions (Brannen, 2005). Mixed-method studies are suitable for collecting primary data for experimental surveys to establish research decisions, such as literature reviews and quantifiable analysis.

Implementing mixed methods in this research clarified the differences between quantitative results and qualitative conclusions. It also anticipated future findings that would help hospice patients experience a quality experience for the future of the industry (Schoonenboom & Johnson, 2017). It contributed to the problem statement of this research by addressing management’s failure to implement high-quality care in hospice facilities around the United

States, resulting in quality control issues and customer dissatisfaction. The qualitative data design provided suitably classic literature answers and a decision-making method that connects the mixed methods to a specifically convergent parallel approach (Johnson & Christensen, 2019). The convergent process linked the research question from a practical and theoretical perspective. It consolidated various ideas and procedures to collect numerical and textual data, which cannot be gathered using a single methodology design in this study (McCusker & Gunaydin, 2015).

Discussion of Quantitative Method

To provide the best possible healthcare, managers need practical methods for decision-making and efficient methods for the management and growth of a healthcare organization (Shahid et al., 2019). For this study, the quantitative research method was utilized to survey healthcare facilities' management and executives, clinical leaders, and hospice cancer clients. Bloomfield and Fisher (2019) illustrate that the quantitative approach investigates data in a countable practice in any research process. The quantitative examination accumulates statistics from the gathered data (Creswell, 2014). The quantitative design fulfilled the parameters of the problem. This study examined critical issues in healthcare organizations to create a reliable foundation for future research and will utilize necessary material and literature reviews. Future research might illustrate the practical implementation of quantitative methods to improve the planning and hospice care system around the United States (Bloomfield & Fisher 2019).

Discussion of Qualitative Method

The qualitative portion of this study used unstructured and non-numerical data (Creswell 2014) by employing the historical empirical archive (Creswell & Poth, 2018). Qualitative research used unstructured, open-ended questions and consolidates data including field notes, observation, interviews, questionnaires, and literature (Creswell 2014). The design examined healthcare facilities management practices and required a phenomenological strategy to observe a distinguished phenomenon within the historical perspective. The qualitative data design established and closed the gaps in prior literature and responded to the decision-making process that combines the mixed method with a convergent parallel (Johnson & Christensen, 2019).

Discussion of Convergent Parallel

A convergent purpose consolidates quantitative and qualitative data, synthesizes the data, and uses the results to understand a research problem (Bloomfield & Fisher, 2019). The convergent parallel design of this study linked the research question from a functional and technical aspect. It combined multiple concepts and techniques to collect numerical and textual data (McCusker & Gunaydin, 2015). A mixed design enabled the researcher to gain quantitative and qualitative perspectives of the quality control issues and patient satisfaction in hospice care.

Mixed methods enabled the study to crosstab on experience levels to gauge hospice organization attitudes, utilizing the research paradigm to define the scope and components of the research. Mixed designs research used triangulation to recognize convergence between approaches, which, in turn, enhances the value and validity of the findings. Combining qualitative and quantitative methods is important. For example, data collection or data analysis typically employs the following three research designs (or topologies) as defined in the discussion in Section 1: Explanatory Sequential Design, Exploratory Sequential Design, and Convergent Parallel Design. The mixed design research of this study utilized the convergent parallel study to harmonize idiographic knowledge with nomothetic knowledge from qualitative and quantitative sources (Creswell & Poth, 2018).

Summary of Research Methodology

The purpose statement and study phenomenon shaped the research design. The design utilized the research paradigm to define the scope and critical components of the research, which ensured that the research questions were adequately answered by discussing the significant quality control issues and potential improvement solutions in hospice care for cancer patients. This reasoning and observation allowed an in-depth multi-faceted frame, for references and the research question, in turn, to organize the concept designs for the study. This study was built on paradigms and was applicable to the social care needed for hospice centers. Thus, the framework highlighted other variables associated with hospice management and the need for leadership management.

Participants

The mixed-method research involved assembling data under controlled contingencies to test hypotheses and empirical factors (Mele & Belardinelli, 2019). The researcher operated on boundaries such as inclusion and exclusion measures to limit population size (Booth, 2018). The research approach in the sampling survey asked participants a fixed set of questions to identify participants' decision-making processes related to hospice management leadership. Sampling is central to the application of the study; choosing participants with experience in hospice who received treatment within United States hospice facilities gave a compilation of data that appropriately depicted the phenomenon of this research. Sampling is also central to mixed purposeful design (Kästner et al., 2021). Manzoor (2020) explains this as engaging more than one sampling approach and simultaneously comparing the results of both samples.

Individuals eligible to be included in the study as a participant were 18 to 65 years of age. For this primary standard, eligibility for participants needed to fit the population of hospice care delivery systems within the United States (Cella et al., 2007). The participants for this study were hospice care patients and hospice care managers within the United States. The researcher selected participants that met the following eligibility criteria: (1) hospice care leadership from centers across the United States that had personal experience in the decision-making processes, and (2) hospice patients who had experience with nurses, doctors, and leadership in their hospice facility.

Population and Sampling

Ashworth (2003) reviews the value of choosing participants that present an understanding of the phenomenon being studied and how that can contribute to the discipline. To achieve the study purpose and in-depth knowledge correlating to the study, the researcher selected participants that met the following qualification guidelines: (1) Hospice care leadership from centers across the United States who had personal experience in decision-making processes and (2) Hospice patients (between 18–65 years) who had experiences with nurses, doctors, and leadership involvement. The researcher developed and implemented a communication plan with the Research Institution organization using their medical records; in the development of this project, this communication plan helped gather and analyze information about the participants to manage leads and determine which participants were selected. The researcher looked for patients with extended stays in hospice, including experiences with management, nurses, and doctors.

The process study recruited management participants who had firsthand experience with the decision-making process to improve hospice care management. Members of leadership were appropriate as they understand behaviors and reasons that drive actions in the hospice facilities. Decision-making has often been described as a moderately shared thinking in hospice care services. Decision-making also gives advice, leading to better care of quality (Manzoor, 2020).

This study recruited 96 participants from the Research Institution organization’s medical records to be interviewed and surveyed with qualitative and quantitative research questions.

The researcher employed a broad range of social media for the process of delivery for the survey questions. Author Hunter et al. (2018) talks about the inadequate directives regarding study recruitment through social media. In 2021, The Collaborative Institutional Training Initiative (CITI) (CITI, 2021) identified the necessity for a coordinated procedure to address privacy, information security, and other questions regarding institutional review board (IRB) submissions to facilitate researchers to utilize social media in an ethical and compliant way to survey participants. Qualified participants were invited to participate in this study via email, phone, Zoom, and by a secured survey link sent to the participant. Eysenbach (2004) describes this process of qualifying participants by email as an internal cognitive means that enables participants to send, receive, and understand messages. During the initial request, the researcher provided each participant with the purpose of the study, and an informed consent form.

Discussion of Sampling

In the mixed-method research, the sampling process was chosen for both the qualitative and quantitative elements of the study (Harrison et al., 2020). Therefore, sampling by the mixed methods approach comprised these seven steps***:***

1. Define the aim of the study.
2. Formulate a specific research objective(s).
3. Determine a particular research purpose.
4. Determine particular research question(s).
5. Choose a particular design of research.
6. Choose the sampling design.

7. Choose the sampling scheme.

The mixed methods approach entailed the use of both qualitative and quantitative measures to access the appropriate population sample. The qualitative portion of the study incorporated the first four of the steps above. The quantitative process incorporated the remaining three steps of the seven previous steps mentioned. These steps are presented in Figure 2.

Figure 2

Seven Distinguished Steps

Note. Creswell et al. (2003).

An example from this figure shows that these steps are linear. Giving triangulation to the study's goal (e.g., explaining the complex phenomena, testing new approaches) pointing to the study objective(s) (e.g., exploration, prediction), in turn, leads to a determination of the study purpose (e.g., triangulation, complementarity), which is followed by the adoption of the mixed methods study method (Creswell et al. 2003).

The purpose of the mixed methods research in this study was to construct both designs in the hopes that it would give both a point of direction (Creswell et al., 2003). Sampling determinations are usually more complex in mixed methods research since sampling methods must be constructed for both the study's quantitative and qualitative research components. Thus, sampling strategies can be categorized according to the time orientation of the features and the relationship of the qualitative and quantitative samples. The mixed-method elements did arise once each phase was used following the convergent-parallel approach is a concurrent approach and involves the simultaneous collection of qualitative and quantitative data (Creswell et al., 2003; Love & Corr, 2021; Tashakkori & Creswell, 2008).

Discussion of Sampling Method. In this research, the convergent parallel design was used to allow sampling to lead to two types of questions, quantitative and qualitative. In the operational process of the research questions, a literature review may be the best methodological tool to provide answers in a mixed-method design. Still, the rigorous evaluation process of the quantitative method examines the evidence of competing qualitative theories (Creswell et al., 2003). The mixed-methods approach allowed for the bridging of evaluation of two areas of concern, specifically the quality of hospice care and the leadership effectiveness. The interview questions were open-ended to facilitate the flow of information and get the complete knowledge, feeling, and understanding of the research problem (Tashakkori & Creswell, 2008).

The researcher focused on probability and purposive sampling within the mixed-method design. The first design in quantitative strategies centers on a wide variety of techniques. It involved research objectives in collecting hospice participants to find the instances that represent leadership and the well-being of patients (Brannen, 2005). To achieve comparability across the study processes, the welfare for better patient quality necessitates the need for the elements of the analysis, such as past literature and research questions. The researcher used a convergent parallel for the quantitative and random purposeful sampling for the qualitative phases. Overall convergent parallel and purposeful random sampling helped meet the study objectives. These objectives allowed the study to meet the confirming and disconfirming problems with patients and leadership in the hospices progress of management. Author Yin (2003) describes these study objectives as revelatory possibility sampling, which involves determination and achieving goals to illustrate a phenomenon.

Convergent Parallel. In this study, the researcher used a convergent parallel approach utilizing comparable samples to help classify research questions into mixed methods. In this study, the convergent parallel approach gave such advantages as non-random sampling because not every constituent in the population had a uniform prospect of being selected as the sample. This allowed for the analysis of sampling schemes to be based on process factors that characterize either solely as qualitative or quantitative, or other than random (Amini Farsani et al., 2021). Convergent parallel was an appropriate approach for this study; this sampling technique allowed the researcher to modify his research methods and results analysis. Because of the cyclical nature of this sampling method, slight changes and amendments can be made during the preliminary parts of the study to correct and hone the research method. The researcher expends little effort when performing this sampling technique. This method is not costly, not time-intensive, and does not require a large amount of workforce (Yin,2009).

Random Purposeful Sampling. The researcher used an illustrative sample to jump off the literature history in this study. The researcher utilized convergent parallel and triangulation synthesis to secure the sequential sampling process with the quantitative strategies phase but allow the qualitative phase to explain its historical data collection (Onwuegbuzie et al., 2018).

Onwuegbuzie and Leech (2005) noted that random sampling tends to be associated with quantitative research, whereas non-random sampling is typically linked to qualitative research. However, the choice of sampling class (i.e., random vs. non-random) should be based on the type of generalization of interest (i.e., statistical vs. analytic). In fact, qualitative research can involve random sampling.

Random purposeful sampling is selecting random cases from the sampling frame and randomly choosing a desired number of individuals to participate in the study. The researcher first accumulated and examined the quantitative data collected from the participants. The qualitative historical data were collected and analyzed second in the sequence and assisted, explained, and elaborated on the quantitative outcomes obtained in Phase 1 (quantitative). The second qualitative phase constructed the first quantitative phase, and the two phases were combined to allow the study to meet its objective of confirming or disconfirming problems with patients and leadership in the hospices progress of management and overall allowing appropriation for this study; this sampling technique allowed the researcher to meet both goal and design of a mixed-method design (Creswell et al., 2003).

Wahyuni (2012) notes the significance of examining questions as they allow the researcher to form a precise and profound understanding of both the participants' answers and the phenomenon of the study. Depending on the extent of the study, sample sizes can vary, and as such, there are no definite rules to conclude the specific sample volume. One common technique concerns answering questions and then developing the research (Tashakkori & Creswell, 2008). This is an attempt to understand the phenomenon, which often reduces the study's risk and allows the protocol to ensure consistency of responses within the research (Creswell et al., 2003).

Discussion of Sample Frame. This study used sampling schemes as a monomethod process that characterizes either solely qualitative or quantitative studies (Amini Farsani et al., 2021). As shown in Figure 2, the seven steps lead into a concurrent process of administration. An example of the concurrent process in this mixed-methods design was examining management leadership strategies with patients that had been accepted at a hospice center for end-of-life treatment. This was facilitated by employing survey and interview questions that contain both closed-ended questions as items (e.g., Likert-format answers that measure approaches toward better quality care) and open-ended questions that elicit qualitative information about better quality of care. The researcher sought to gather both forms of data concurrently; the researcher compared both forms of data to search for corresponding conclusions (e.g., how the theory distinguished in the qualitative data corresponds with the statistical outcomes in the quantitative study (Creswell et al., 2003).

Discussion of Desired Sample and Sample Size. This study represented a sample of 96 participants, to allow a full exploration of the significant gap in research regarding the critical issues of hospice care quality and leadership effectiveness to provide a contribution to the research of this area. The sample size affects the hypothesis and the research plan, and there is no straightforward process of determining the sufficient sample size for reaching an accurate result (Creswell et al., 2007). Employing a chi-squared test raised the ethical standards of the study by determining the significant difference between the expected frequencies in one or more variables within the study. The primary aim of the study was to find statistical significance in the relationship of better-quality care and leadership in hospice care (White, 2016). Guidelines in determining the study's quantitative process was considered the Length of Stay (LOS) for patients enrolled in hospice in 2018, which was 89.6 days (Nhpco, 2021). The guidelines set by National Hospice and Palliative Care Organization (NHPCO) assisted in determining eligibility in this study by specifying the Length of Stay (LOS) for patients enrolled in hospice in 2018, which was 89.6 days (Nhpco, 2021). Surveying participants involved active, recent, or past patients of hospice who had experiences with employees (doctors, administrative, nurses) and were part of Research Institution organization’s medical records within the United States. The process of sampling is meaningful and vital to the mixed methods study design; there is a lack of rigorous methods for sample size calculation in this setting. This study aimed to develop the recommended sample size from the total eligibility of participants not going over 96 participants.

Within the qualitative portion of the research, saturation is reached when responses to qualitative questions are repeated frequently. This is especially essential when the researcher is more selective about where resources are positioned to form research opportunities. Unlike quantitative studies, where much research exists to select statistical computation and potency, quantifying the number of qualitative study participants has not been a strong research focus (Creswell et al., 2003, Harrison et al., 2020). While the concept of saturation is complicated for qualitative sampling procedures, the answer to how many interviews is necessary is unclear, and according to Saunders (2012, p. 283), no regulations exist. Morse (1995) comments that if saturation is not reached, it does not nullify the study results; instead, it simply denotes that the subject is not thoroughly studied.

In achieving saturation in this study, the researcher's experience was advantageous to pre-dispose a view. For example, having a minimum number of interviews was needed regardless of saturation. While a specific number was not practicable, some numerical approaches, as explained within the quantitative discussion, helped sustain and support the qualitative design. Pratt (2009) notes that qualitative study is excellent for understanding the how-to question, rather than how many questions are needed. The researcher stayed in that commonplace of understanding the phenomena from a researcher's perspective.

Summary. This mixed-method study evaluated hospice care service and leadership. The survey sample size used 96 participants within the United States hospice system and focused on necessary end-of-life care that incorporates consideration for patient requirements on various levels. Quality of care needs addressing in hospice care services, and the obligations to and satisfaction of the patient are fundamental for better quality from hospice management. The research questions in this project facilitated the discovery of information that can help fill the gaps and add to the existing body of literature through discussions concerning the quality of care and improving the hospice system within the United States.

Data Collection and Organization Phase I Quantitative and Phase II Qualitative

The primary data collection used mixed-methods to address the different research questions or process information from the ranks within the hospice system and utilized the Research Institution organization's medical records. Mixed-methods studies allowed the researcher to match multiple data formats, permitting more in-depth knowledge of a phenomenon, which is vital in the hospice industry where leadership needs a decision-making strategy that can address the challenges of providing quality and patient satisfaction (Almeida, 2018).

Data Collection Plan for Phase I and Phase II

The quantitative and qualitative study designs create a convergent parallel strategy (Muhaimin et al., 2019). Data collection plans for this research involved surveying active, recent, or past patients of hospice who have had experiences with employees (doctors, administrative, nurses), and employed Research Institution organization's medical records within the United States. The appropriate plan for the research project data employed mixed-methods. The researcher collected and analyzed both quantitative and qualitative data employing closed-ended and open-ended questions, unstructured and structured data collection interviews, survey questions, and archived data. Before each participant engaged in the study, they were given an informed consent form to review and consent to (Appendix A).

Onwuegbuzie et al. (2011) shows the characteristic process within a mixed-method study; these methods help this researcher in the collection process, expanded the existing knowledge and provided an understanding of the resources available for exploration to develop the research. The instrumentation process promoted validity, was ethical, and allowed for integrating data collection and interpretation. In turn, the researcher shared preliminary results with the participants to ensure data accuracy (Gadke et al., 2021). Due to the anonymous framework of the data collection, participants will have to request a summary of the findings after the dissertation manuscript is published.

Member Checking Qualitative Data Phase II

The researcher validated data by confirming the credibility of the results. For example, data or results were returned to participants to review, which facilitated trustworthiness and validation. In the process of member checking the researcher returned data, analytic categories, data interpretations, and/or even conclusions to study participants. The argument is that by giving participants the opportunity to review research work, a researcher can claim that the work adequately presents "own and multiple realities" (Hancock et al., 2021). As suggested by Lincoln and Guba (1985), member checking can be performed formally or informally. Amin et al. (2020) linked member checking to a list of validation techniques such as trustworthiness and validation.

Follow-up Interviews Qualitative Data Phase II

During the interview, the applicants were asked questions, and the answers were valuable sources of information for the research. Some of the research questions were open-ended so that the answers given helped in determining the process within the mixed-method design. Each design provided a relationship to help determine the strategy. The researcher included open-ended questions with each survey for the qualitative portion and with the hope that participants would fully express their beliefs without being constrained. Overall, this process assisted in obtaining depth and richness that allows for exploring the underlying meanings of the quantitative portion. Open-ended questions by themselves do not make a qualitative study into mixed-methods research, but overall, the design of the qualitative portion makes it a mixed-method design (Creswell, 2014). Lastly, a significant motivation for qualitative follow-up research is to demonstrate that the results support the qualitative results and have substance that extends beyond the specific context of those results. The researcher's objective was to utilize the strengths of qualitative methods to show the greater generality of the original qualitative findings (Onwuegbuzie et al., 2018). Follow-up with participants was essential in providing sufficient structure, detail, and guidance for the research process and support the credibility of the questions and responses (Hancock et al., 2021).

In any investigation, the informed consent process is done primarily by getting the research participant's signature on the consent form (Creswell, 2014) (see Appendix A). The consent process in this study included follow-up, getting adequate information to qualify to make an informed decision, giving sufficient time to ask questions, obtaining voluntary agreement, and providing information as the research progresses and the situation requires it (Wexler et al., 2021). The interview questions were open-ended and phrased to minimize anxiety and allowed follow-up within the process of concurrent queries (Creswell, 2014).

The follow-up interviews for the qualitative research portion allowed the researcher to create a complex, holistic picture by examining words, and report detailed views of the collected information. Finally, the researcher conducted the study in a natural environment (Creswell, 1998, p. 15). The researcher constructed knowledge claims based on the constructivist (Hancock et al., 2021) or advocacy/participatory perspectives (Creswell & Clark, 2017).

Instruments for Phase I and Phase II

Developing a mixed-methods study instrument and preparing a standard to examine participant conceptions required developing a thematic analysis of collected data (Creswell, 2014). The researcher outlined the steps by designing, validating, and analyzing this mixed-methods instrument. In particular, the research illustrated the iterative and time-intensive nature of the mixed-methods investigation, both in representing the pre-investigation procedure and post-investigation research, and what it offers to empirically based insights into the instrument and standard development strategy (Onwuegbuzie et al., 2018). These standard development strategies are set below by interview guides, surveys, and archive data.

Phase I

The researcher served as the primary data collection instrument in this study, using a closed-ended questioning process. A Likert scale from 1 to 5 was used to assess variables of management leadership processes within hospice facilities within the United States. The survey included five questions. The researcher utilized a consistent instrument that aimed to have satisfactory construct validity, measure the researcher's aim in the study process for quality of care for hospice care, and used multiple measurements to enhance construct validity (Onwuegbuzie et al., 2018**).**

Phase II

The researcher served as this examination's primary data collection instrument, using an open-ended questioning process through semi-structured interview questions as the primary data source. The questionnaire was collected from qualified participants of this study. The interview included two qualitative questions, allowing the participants to discuss critical matters concerning the subject. Semi-structured questions are meant to be unique and personal, allowing for more open and direct encounters; verbal questions elicit detailed descriptions and reports (Creswell, 1998).

Phase I Quantitative Instruments

The quantitative phase of this study identified internal and external factors contributing to management's failure to provide high-quality cancer care in hospice healthcare facilities in the United States, resulting in quality control issues and customer dissatisfaction among cancer patients. The transverse study strategy implied that the data are collected at a particular point, was used to measure the management leadership process (Onwuegbuzie et al., 2018). A cross-sectional or transverse study is a type of observational study, or descriptive research, which analyzes information about a population at a specific time. Typically, these studies are used to measure the prevalence of health outcomes and describe the characteristics of a population (Setia, 2016). Cross-sectional studies looked at a population at a single point in time like taking a slice or cross-section of a group, and variables are recorded for each participant.

The primary technique for collecting the quantitative data was a questionnaire containing self-assessment items, measured on a 5-point Likert scale, and closed-ended questions organized into sections or scales. The first section of the survey asked questions related to key management issues affecting the quality of hospice care for cancer patients. It included the selection questions about factors contributing to the leadership decision-making process to improve patient quality. Question 5, question 6, and question 7 measured evidence-based guidelines and protocols in getting hospice services. These questions focused on selected external factors have influenced participants' progress in hospice centers. These questions were measured on a 5-point Likert scale of *Very Good, Good, Satisfactory, Somewhat Satisfactory, Very Unsatisfactory*.

Discussion of Quantitative Survey Questions

The researcher employed a structured questionnaire in the surveys (see Appendix B). The instrumentation's reliability is presented and starts by defining validity and reliability; it is essential to understand the term before collecting data. Determining the validity refers to determining the accuracy of the measurement outcome, which is also the extent to which the measurement measures (Flynn et al., 1994; Creswell & Creswell, 2017). The researcher employed the chi test to evaluate the internal reliability of the instrument (White, 2016). It helped each variable be similar or correlate to one another by defining reliability and validity. The instrument chosen to measure variables in this study listed three critical fundamental characteristics (Independent, Intermediary, and Dependent Variables) related to validity and reliability. The instrument selection used was based on the foundation of choosing an instrument that considers their characteristic psychometric measurement measures for quality of care for patients. The researcher looked at the three key characteristics and focused on how the instrument measures the management and quality of care to address various needs among patients in hospice care. The researcher identified a measurement process that includes safety, social, and self-esteem that is identified as variables in this study to measure management leadership effectiveness (Onwuegbuzie et al., 2018).

The researcher employed a consistent instrument that aims to have a good construct validity, measures the researcher's aims in quality of care, and has multiple measurements into improving construct validity (Onwuegbuzie et al., 2018). The main reasons for that are that the participants and interests are usually multi-dimensional, which means one measurement may vary based upon the median of the examination, thus impacting results, and occasionally discharging multiple instruments or measurements that can improve the construct validity (Flynn et al., 1994).

The need for multiple types of validity and reliability are established within the process of the instrument. Creswell and Creswell (2017) mentioned the different kinds of contemporary, predictive, and concurrent validity ideal for the researcher within the quantitative measurement. The researcher used the validation process to predict and correlate similar results. For example, in developing a survey, the style of the instrument may influence the participants. Overall, the researcher used an established factor or principal component analysis, specifically a journal or some other format of psychometric characteristics. This process included knowing the common types of reliability, like internal consistency reliability, and how they correlate to the participants; this is sometimes known as the test-retest factor, which also shows the measurement of the process over time (Flynn et al., 1994).

Discussion of Survey and Research Questions

This discussion addressed how the research survey relates to the research question. Each survey question focused on a quantitative perspective of the hypothesis. Each survey question is the same as the research questions. Each survey used seven sub-questions leading into the question perspective in relation to the phenomenon of the study. The design guided the research and led to systematic planning for the study (Creswell, 2014). The surveys had two sections; the first section used a Likert scale, rating questions from one to five. Overall, the answers were developed using a chi-square statistic program into the software, leading to a non-parametric (distribution-free) tool designed to examine group differences and dependent variables (Creswell, 2014). This research project followed a more extensive and diverse process, leading with the raw material from the quantitative question regarding hospice administration and backing the qualitative historical portion (Stake, 2010).

Quantitative Survey Questions Relating to Research Questions

RQ1. What are the key management issues affecting the quality of hospice care for cancer?

A. How would you rate where your hospice care was delivered?

This response scale ranges from 1 (*very good*) to 5 (*very unsatisfactory*).

RQ4. What is the relationship between care needs for different types of cancer patients and patient satisfaction?

B. How satisfied were you with the type of cancer services you received?

This response scale ranges from 1 (*very good*) to 5 (*very unsatisfactory*).

RQ5. What improvement interventions should U.S. hospitals adopt for the efficient management of cancer patients?

C. How important are performance indicators in the efficient management of cancer patients?

This response scale ranges from 1 (*very important*) to 5 (*not important*).

RQ6. What evidence-based care interventions have been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients?

D. How important are evidence-based guidelines and protocols to you in getting hospice services?

This response scale ranges from 1 (*very important*) to 5 (*not important*).

RQ7. To what extent is there a relationship linking aggressive symptom management and intense hospice care in providing high-quality hospice care or resulting in low-quality care and management issues?

E. To what extent do you feel management issues influence the quality of hospice care for cancer patients?

This response scale ranges from 1 (*not at all influential*) to 5 (*extremely influential*).

Discussion of Survey and Relationship to Research Questions

Discussion of Quantitative Research Question One.

RQ1. What are the key management issues affecting the quality of hospice care for cancer patients?

A. Survey: How would you rate where your hospice care was delivered?

Question one refers to critical management issues affecting the quality of hospice care for cancer patients. The hypothesis connects with determining the statistically significant key management issues affecting the quality of hospice care for cancer patients, and whether there is a link in how those issues affect the quality of hospice care for cancer patients. A survey (A) was correlated to a management question asking participants where their services were administered. In particular, the survey question utilized self-reporting (i.e., questions asking participants to rate management services or leadership). The critical need for respect for patient care in hospices can benefit leadership in providing for patients facing end-of-life care. The unique circumstances confronted by these patients and their families, policymakers, and administration must include high-quality care and information provided to patients (Montes-Galdeano et al., 2021).

Discussion of Quantitative Research Question Four.

RQ4. What is the relationship between care needs for different types of cancer patients and patient satisfaction?

B. Survey: How satisfied were you with the type of cancer services you received?

To explore the status quo of assessing the relationship between care needs, admitted inpatients versus outpatients were evaluated based on survey location. Applying an adapted relationship scale, the study determined the occurrence relationship based on satisfaction with different relationships as perceived by hospice health care professionals within the United States. Interprofessional working relationships can impact the quality of collective approaches, affecting patient safety outcomes. This survey question evaluated the participant relationship scale incorporating different hospice care facilities around the United States, employing the study variables, and varying from negative to positive, between hospice healthcare professionals: doctors, nurses, dieticians, occupational therapists and each role member or position are specified before each interview. This survey question investigated the status of interprofessional collaboration in hospice centers within the United States. The survey results helped in recommending strategies for advancing interprofessional cooperation in improving relationships (Onwuegbuzie & Johnson, 2021).

Research Question 4 refers to the relationship between care for cancer patients’ needs and the statistically significant hypothesized relationships. These relationships focus on patients' needs and satisfaction with health-related quality of life, which is the focus of the study. The patients may link satisfaction with care, but the relationship may not be apparent in many hospice facilities. For example, patients may need more or better information concerning some element of end-of-life services. If the need remains unmet, it may result in dissatisfaction with the end-of-life services. Alternatively, the better-informed patient tends to have higher expectations and may not be dissatisfied with the care (Reggio et al., 2021). These scenarios directly influence patients’ quality of life and hospice care services. The challenge, therefore, was to pinpoint patients’ needs and understand management issues in meeting those needs, helping to deter further expenses, maintain patients' satisfaction with hospice services, and guide patients to a more satisfactory quality of life. At the moment, Research Question 4 helped define the needs and the research concepts within the context of hospice care, yet it made sense to describe this intrinsically complicated issue as to what purpose the relationship of patients and the population as a whole were to the practitioners in the hospice leadership. In turn, each process can produce open decisions or judgments leading to implicit knowledge rooted in professional training and values, office culture, and the assumptive world (Alexanian et al., 2021).

Discussion of Quantitative Research Question Five.

RQ5. What improvement interventions should U.S. hospitals adopt for the efficient management of cancer patients?

C. Survey: How important are performance indicators in the efficient management of cancer patients?

Research Question 5 refers to improving interventions that should efficiently help U.S. hospice care facilities adopt better management processes for cancer patients and shows the hypothesis process. The survey question helped influence the operation base decision, which can help provider interventions and can facilitate additional testing and use of evidence-based practices. In contrast, member interventions can help the intervention process for management behaviors essential for a patient's decision-making. Hospice systems within the United States are under growing stress to improve outcomes, whether they function as a fee-for-performance or value-based care for-profit or non-profit (Aguirre Polanco, 2018). This particular question is noted in building the theory of this study. Focusing on the for-profit or non-profit question gives established remuneration models for the hospice services in the United States. The shift shows increasing cost pressures in the hospice sector. Fee-for-performance and value-based systems are increasingly substituting fees for service. Major players—including Medicare and Medicaid in the United States—play a decisive role in choosing hospice and hospital value-based performance and better quality of treatment that, in turn, plays a decisive role in selecting a service (in addition to price and access to care) (Rhoads et al., 2014).

Discussion of Quantitative Research Question Six.

RQ6. What evidence-based care interventions have been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients?

D. Survey: How important are evidence-based guidelines and protocols to you in getting hospice services?

Research question six refers to the evidence-based care interventions that have been implemented in the U.S. healthcare system and asked how to improve treatment outcomes and satisfaction among cancer patients. The survey question portion asked about the importance of hospice services, linking the question to the study phenomenon.

Evidence-based care interventions question the need for aggressive, preventative, or curative interventions. Corrective intervention has a high cost and different outcomes when administered for cancer patients. Evidence-based interventions are techniques that are confirmed to work, but with leadership working together (Lacerenza et al., 2018). Overall, these interventions enhance cancer screening quality and boost the number of people screened for cancer.

Discussion of Quantitative Research Question Seven.

RQ7. To what extent is there a relationship linking aggressive symptom management and intense hospice care to management issues, resulting in high-quality hospice or low-quality care?

E. **Survey**: To what extent do you feel management issues influence the quality of hospice care for cancer patients?

Research Question 7 discusses the relationship between aggressive symptom management and intense hospice care and management issues resulting in high-quality or low-quality care. The survey portion and question link the concept of choosing aggressive treatment over quality of care. This study showed a statistically significant relationship linking aggressive symptom management over quality of care, beginning with early hospice services, which may require months of considerable care and result in more quality moments with loved ones (Li et al., 2018). The mixed study process evaluated the development of course of treatment over time among patients with advanced cancer receiving care in hospice centers. To assess statistical significance, Cox regression analysis will be used to assess the differences in the probability of survival for a cancer patient. Overall, this process helped report outcomes and scores of analyses (Akin et al., 2018).

Phase II Qualitative Instruments

The second phase of the study used qualitative methods to explain the results of the statistical examinations obtained in the first quantitative phase. Researchers often employ ethnographic design for a qualitative portion (Creswell, 2014; Onwuegbuzie & Johnson, 2021) and explore a mixed-method approach through detailed, in-depth data collection involving numerous sources of information that are rich in context (Onwuegbuzie et al., 2018). In this study, the process of gathering information (Schoonenboom & Johnson, 2017) suited the intention of this study and bring light to particular problems (Creswell, 2002, p. 485), such as management's failure to provide high-quality cancer care in hospice healthcare facilities in the United States, resulting in quality control issues and customer dissatisfaction among cancer patients. The primary technique conducted in-depth semi-structured interviews with selected participants and employing open-ended interview questions. Triangulation of distinct data sources is essential in mixed-method analysis (Creswell, 1998).

The interview protocol included two open-ended qualitative questions and a closed-ended questions survey. The range of the protocol questions grounded in the results of the statistical examinations of the associations between the participants' and the predictor factors in addressing management's failure to provide high-quality cancer care in hospice healthcare facilities in the United States, resulting in quality control issues and customer dissatisfaction among cancer patients. Two qualitative questions focused on the management issues that contribute to patient outcomes. The survey portion also helped show the importance of hospice service. The second question assesses patient needs in cancer care and how these can contribute to quality control issues and patient satisfaction overall, in the hopes of showing connectedness with the hospice center visits. The study interviewed 96 participants selected from the target population. The participants were given interview questions before the scheduled interview, and the researcher recorded the interview and transcribed it verbatim. Respondents had a chance to review and, if necessary, update the interview contents after they had been transcribed.

This research study consisted of seven questions set up in a concurrent format. The questions focused on the patients’ quality of services and leadership needs, allowing the participants to openly discuss crucial issues. The instrumental function of the researcher in the mixed methods research project focused on responsibility in completing the study (Schoonenboom & Johnson, 2017). Semi-structured questioning is subjective and enables patients to explain their encounters through open, candid, verbal questions, which elicit detailed narratives and accounts. The researcher asked the same two qualitative questions of each participant to keep consistency and assure the reliability of the data collected. The interview guide in Appendix C provides a sample of semi-structured questions that will be used.

This configuration permitted the researcher to ask questions to prompt a specific discussion and enable independence to move the conversation in any order of interest that may come up. More importantly, it gave a characteristics use of words in the quantitate prospect of study to align with the qualitative portion of the study (Onwuegbuzie et al., 2018).

Discussion of Qualitative Questions and How It Relates to Questionnaire

Discussion of Qualitative Question Two.

RQ2. How does each management issue contribute to patient outcomes?

Questionnaire: A. What experience or miscommunication have you had with a hospice center? How did you solve the problem?

The interventions, patient behaviors, and health determinants were documented for patient outcomes to be most meaningful. Interventions included management assessment, hospice health coaching, and nurse phone calls in addition to pharmaceuticals, treatments, and patient outcomes (Kreuter et al., 2017). More importantly, hospice services have a common misconception about comfort measures, such as in terminally ill patients and the number of days they might have. How does management handle those last few days? Hospice care helps patients with life-limiting illnesses live their final months in comfort and dignity. More important, management and doctors must certify the primary terminal illness and agree with the natural course of the illness, and that the patient's life expectancy is usually six months or less (Akin et al., 2016). Patients are eligible for hospice care after this physician certification. If at this time, a person is not yet ready to proceed with hospice care, a hospice referral can be placed later. Given that no one can accurately predict the time of death for a terminally ill patient, the hospice benefit allows patients to remain in the program as long as they continue to meet the criteria (Kreuter et al., 2017).

Discussion of Qualitative Question Three.

RQ3. How does the assessment of patients' needs in cancer care contribute to quality control issues and patient satisfaction?

Questionnaire: B. What has been your experience in dealing with the staff, doctors, nurses, and leadership? Give me an example.

Question 3 focused on management issues that contribute to patient outcomes and assessment of patient needs. Patient care services in hospice centers are necessary to patients' physical and emotional well-being and can enhance their quality of life and lengthen their lifespan. A strong connection with the patient is necessary; and the interview question helped facilitate a connection with the patient. The question provided insight into how relationships are enhanced. Advancement interventions are essential, such as decreasing the nurse-to-patient ratio and lowering hospital mortality rates (Akin et al., 2016). Gallan et al. (2019) stresses the importance of the cancer patients' physical treatment process, and that community well-being can be transformed through patient quality of care.

Assessing patient needs in cancer care requires identifying quality control and patient satisfaction issues (Akin et al., 2016). These questions identified or clarified the issues of the general quality control that contribute to low patient satisfaction in cancer care (Kreuter et al., 2017).

Many prominent scholars and researchers feel that a quantitative and qualitative design (mixed methods) is a compatible process within any research procedure (Onwuegbuzie et al., 2018). Tashakkori and Teddlie (2008, p. 9) discuss options elected in the positivism approach.

Positivism embraces the view that only factual knowledge gained through observation, including measurement, exists trustworthy. In the positivism process of studies, the role of the researcher is restricted to data collection and interpretation objectively. Johnson and Onwuegbuzie (2004, p. 14) specify the origins of mixed-method and how it lies in the two primary research paradigms.

The choice is essential to the research approached because it allows quantitative and qualitative research questions to be used appropriately (Hiver et al., 2021). In this study, the researcher aimed to understand the management leadership role played in hospice facilities to obtain better quality of care by collecting data from each participant and analyzing the richness of each experience. Creswell (2014) posits that the instrument process develops the questionnaires and assesses the material obtainable for inquiry. Stake (2010) refers to the researcher as the interpretative investigator that studies the data for new insight.

Data collection for this study utilized what Johnson and Onwuegbuzie (2004, p. 14) referred to as a process of complementary shifting to ensure all stages within the mixed-methods data process are covered. The method of research activities will always center on ethical practices within the data collection; this consists of locating a site and individuals, acquiring credentials, constructing a rapport, usage of purposeful sampling, data collection, recording information, analyzing field matters, and safely storing participant information (Creswell, 2014). The researcher focused on using a metaphysical phenomenological strategy, since it focuses on participants' experiences and less on interpretation (Creswell, 2014). The metaphysical technique also contributed to reliability and validity, as it offers a methodical strategy to answering the research questions (Johnson & Onwuegbuzie, 2004, p. 14). Creswell (2014) described that a researcher's open-ended questions are critical when conducting research. Accordingly, within this research, the principal instruments of this study consisted of the researcher's investigation and findings of the data accumulated from the open-ended questions to acquire answers from participants.

Onwuegbuzie and Johnson (2021) explained ethical concerns within a mixed-methods study, particularly in the data collection stage. The authors noted that the top three ethical concerns are consideration for the participant in the study, the welfare of individuals, and trust. The researcher considered these aspects and addressed all common emergent ethical issues associated with this study, especially respecting participants. The researcher planned for participant rights and privacy by having participants sign consent forms; this will help protect participants and maintain integrity and justice. The consent form privacy clause was explained giving the nature and purpose of the study and allocating numbers for each participant, so protection of identity is assured.

Another critical concern is obtaining permission from the Institutional Review Board (IRB) (Onwuegbuzie & Johnson, 2021). Creswell (2014) notes that the IRB process requires that research follows the guidelines for ethical research. Notably, in this study, the IRB process assures the participant that the study has been authorized. The IRB process mandates that a researcher submits a proposal that describes how the selection and approvals for both the participant and researcher are administered to demonstrate reliability and validity (see Appendix A).

Qualitative Survey Open-ended

RQ2. How does each management issue contribute to patient outcomes?

Questionnaire: A. What experience or miscommunication have you had with a hospice center? How did you solve the problem?

RQ3. How does the assessment of patient need in cancer care contribute to quality control issues and patient satisfaction?

Questionnaire: B. What has been your experience in dealing with the staff, doctors, nurses, and leadership? Give me an example.

Discussion of Archive Data for Phase I and Phase II

The researcher counted on historical archive data for the qualitative portion to back the qualitative part of the study. The historical archive data is necessary for the study to present strategies to provide valuable and unusual information. Each research question and survey are relatable to the interrelationships between leadership, patient knowledge, and facility practices (Creswell & Poth, 2018).

Phase I. Within the process of data archiving, data mining was developed into predictive modeling. White (2016) talks about predictive modeling using historical data trends or patterns in helping conclude the research. Statistical benchmarks, such as Statistical Package for the Social Science – Version 28 (SPSS-28), or cluster analysis are utilized to formulate models that distinguish the possible outcome. For example, the predictive model may accurately determine or predict the length of stay for hospice patients based on their reason for acceptance and the functions to be performed during their hospice visits or stay. More importantly, the leadership management utilization process links into each research question about having a better quality of care for patients.

Phase II. The usefulness of archived qualitative data is essential to back the contextual information surrounding future research findings within the study. The researcher revisited research participant experiences from their collected data and discussed highlights central to the study with the participant. This helped concentrate on the critical feature of qualitative research across hospice care and quality for disciplines and implications for the archiving and re-using qualitative data (Creswell, 2014).

Data Organization Plan for Phase I

The researcher undertook the process and development of the research plan, which includes the complete data collection, analyzing experiences and outcomes, and drawing conclusions to expand knowledge from interviewed participants. Minimizing biases and confounding processes within the study relies principally on purposeful sampling. The design helped maximize the data acquired from the interviews (Creswell, 2014). Research results and recommendations were entered into SPSS-28 (for phase one), which was used to assess the differences in the probability of management leadership role. Overall, this process helped report outcomes and analyze scores (McGregor et al., 2020). The researcher used data organization to analyze experiences and concluding results. Creswell (2014) referred to data organization as coding, which organizes data into a standard storyline or developing theory. Jose et al. (2020) defined coding as categorizing data into concepts, ideas, and issues relevant to the research project. The researcher used coding to determine trends, resemblances, consistencies, and inconsistencies that explains each member's hospice experiences, which was then analyzed. All data was secured electronically using encryption software or password security to protect participants’ privacy (Creswell, 2014).

Data Organization Plan for Phase II

Creswell and Poth (2018) asserted that qualitative concepts in a mixed-method should explain the results of the statistical tests obtained in the first quantitative phase. The qualitative design (Creswell, 1998) explores a bounded strategy or an in-depth data collection implicating numerous sources of data that are rich in context (Onwuegbuzie and Johnson, 2021). In this study, multiple instruments were administered with the intent of illuminating a particular topic (Creswell, 2002, p. 485), such as persistence in getting a better quality of care in hospice systems. The primary approach conducted in-depth semi-structured interviews with the questionnaire. Triangulation of different data sources is essential in mixed methods research (Creswell, 1998). Research Institution medical records and transcripts were used to validate the data acquired during the interviews. The participants were asked for consent to access their transcripts, while the information collected will be kept private from any other party. The participants received the interview questions before the scheduled interview and were informed that the discussion was recorded and transcribed verbatim. Participants were allowed to review and, if necessary, update the interview contents after transcription. The data collected from the qualitative portion was entered into NVivo or an equivalent qualitative analysis software to help triangulate the mixed-method study.

Summary of Data Collection and Organization Phase I and Phase II

In the data collection and organization process, the researcher functioned as the instrument to design the research strategy, complete data collection, understand participant experiences and outcomes, and build knowledge gaps within the study. The data collection included establishing the study's boundaries, employing closed and open-ended questions, and utilizing SPSS-28 and NVivo. The researcher continued data collection until saturation is met. Once this goal was obtained, the researcher organized the data into meaningful classifications that were examined and analyzed to develop knowledge and fill gaps within the topic of research.

Phase I. The quantitative discussion and data collection procedures, instruments, and data organization plan were provided above. The quantitative portion requires the grouping of processes, using statistical computation to infer the opinions and mindsets of participants (Creswell & Creswell, 2017). Onwuegbuzie and Johnson (2021) talk about quantitative research as the process of collecting and analyzing numerical data and how it can be utilized to discover patterns, averages, and to make predictions. As such, the quantitative portion shows the process of developing a survey instrument that will be used and how it will be linked to collect data and organization.

Phase II. The qualitative discussion and data collection procedures, instruments, and data organization plan was provided above. The use of semi-structured questionnaires allowed the researcher and participant the flexibility to openly ask and answer questions. The open-ended inquiry methods help maintain the process of this research. For example, the interview techniques explore the contextual aspects and rationales for risk behaviors that do not fit correctly into predefined types or study variables (Creswell & Creswell, 2017).

Data Analysis Phase I Quantitative

In collecting data, the interview process helped researcher-development of transferable skills and enhances research employment potential (Head, 2020). The study portion for quantitative data analysis helped answer the qualitative part against historical gaps (Creswell, 2014). The collected data were analyzed to help answer the research question of how hospice leaders can provide a better quality of care and emphasize value-based patient care. Examining and processing mixed-methods data includes various steps (Creswell, 2014). The foundation of this analysis focused on dismantling and reassembling the collected data to indicate codes and themes to enhance the understanding of participants' ideologies within the research (Sarauw et al., 2019). As proposed by Yeşil and Doğan (2019), the data collection process must provide a clear understanding of the participants' personalities and traits and enable the researcher to relate to the participant. Grech and Grech (2021) described a mixed-methods process in a sequence of data collections. They show points at which the data are integrated at collection, analysis, interpretation, and finally, combination. To help understand the research issues, the researcher prepared the data for analysis by managing and coding to acquire the results, following ethical guidelines formulated by the Belmont Report (Grech & Grech, 2021). The Belmont Report provides guidelines for research and stresses getting consent to participate in the investigations (Miracle, 2016). The quantitative portions were input using Statistical Package for the Social Science – Version 28 (SPSS-28). The qualitative portion used NVivo or equivalent qualitative analysis software. The data collected from the quantitative portion were analyzed with the qualitative part of the study and entered into the software to help determine if a correlation exists between the intermediary variables leading to the quality of care for the independent and dependent variables.

The Variables for Phase I

This research contains three variables: independent, intermediary, and dependent variables. The framework and application were used to necessitate the variables employ the Chi-Squared Test of Independence which offers practical support to patient flow by examining the relationship between variables (White, 2016). As illustrated in Table 1, the Chi-Squared variables, and Theories Symbols as χ2 generate each variable into each research question. In this study, a Chi-Squared Test was developed by hand to make the examination more manageable (White, 2016). The variable supports each research question in leadership and management styles for better patient quality of care. Table 1 gives a sample of each variable in the study and format with the statistical design to a ratio formulation comparing each variable scale to a range.

The chi-squared test of independence tested participants' answers from different hospice center healthcare facilities. The study sampled 96 employees or patients. Before testing the hypothesis, the alpha level is set to five percent. Table 1 shows each variable that was tested, which includes independent, intermediary, and dependent variables. Recall the formula for the chi-squared test as: $\chi 2 = \Sigma i, j (O ij - E i j) 2E i j$.

Table 1

Categories for Variables

Independent Variables	Intermediary Variables	Dependent Variables
Quality of Life	Maslow's Motivational Theory	Feedback of Hospice Management
Hospice Care	Needs Among Patients/Hospice Clients	Safety, Social, and Self Esteem
Hospice Patient Experience	Leadership Management	Self-Actualization

Note. The data in this table shows variables for management leadership in addressing quality of care for the patient. From this sample alone, there appears to be a relationship between needing leadership for a better quality of care for patients encountering the variables that will be tested. A chi-squared test will be used to test the null hypothesis for hospice services for better quality that tests the status of the independent process. The chi-squared test can assist in determining whether the relationship is significant. Before testing the hypothesis, the alpha level is set to five percent (White, 2016).

Descriptive Statistics for Phase I

The $\chi 2$ represented nominal data in the horizontal heading category presented in Table 1. The table data suggests effective leadership styles are needed to provide patients with a better quality of care. The relationship between better quality of care and dissatisfied patients will be tested for correlation to leadership management. There is a need to enhance access to hospice care management for cancer patients' quality of life (QOL) and experience. Patients with advanced cancer and their families often encounter management barriers to hospice admission and challenges in getting hospice cancer care services (Haverhals et al., 2018). A chi-squared test was used to test the quality of the data and determine the relationship. White (2016) talks about the alpha level being set to five percent before testing the hypothesis. The initial phase in employing any hypothesis testing process in statistics is understanding the null and alternative hypotheses. In the engagement of the chi-squared test, the null hypothesis has no relationship between the categorical and independent variables (Creswell & Poth, 2018). This is important in a mixed method study for keeping the study authentic (Onwuegbuzie et al., 2018). After the process of employing the chi-squared test, the researcher inputed the statistical data into statistical software, such as SPSS-28, which allows a researcher to develop descriptive statistics that will be used to represent a single variable (univariate examination) or more than one variable (bivariate/multivariate examination). In the circumstance of more than one variable, descriptive statistics can assist in summarizing relationships between variables using tools such as SPSS-28 (Rodgers-Melnick et al., 2022).

Hypotheses Testing for Phase I

The hypotheses focused on the proposed study phenomenon and the research question. The focus was on the independent intermediary variables for patient quality of care and leadership management that link current and past (White, 2016). The value of the hypothesis is also significant to test the statistic and prevent error. White (2016) stated that the smallest value or mistake for which the null hypothesis can be rejected is called the p-value and is set to 0.005 or 0.5 percent. This means that the null hypothesis or hypotheses testing alternatives can be rejected even if the error rate was set to 0.005 or 0.5 percent. The p-value for a hypothesis was tested and documented at the beginning of the survey, and available to determine whether the error rate is acceptable in the research process. The research questions will address the hypothesis process and focus on the variables.

Hypothesis Discussion as it Relates to Each Question

Quantitative Hypothesis for Question 1.

H1o: There are no statistically significant key management issues affecting the quality of hospice care for cancer patients.

A survey question can be made into a hypothesis by revising it into a statement (Creswell & Poth, 2018). In this current study, the hypothesis for H1o will correlate with question number one and investigate the relationships between the key management issues and the quality of hospice care for cancer patients. This research is important to provide insight into hospice healthcare centers' perceptions of their quality of care and link to the variable prototypes of independent, intermediary, and dependent variables. The provision of these variables was linked to the quality of care in cancer treatments, showing the growing significance of the patient experience (Pesut et al., 2020).

Quantitative Hypothesis Question for Questions 4 to 7.

H4o: There is no statistically significant relationship between care needs for different types of cancer patients and patient satisfaction.

The hypothesis for H4o addresses the relationship between care needs for different types of cancer patients and patient satisfaction for question four of the survey. More importantly, the hypothesis centers on the two variable prototypes of independent and dependent variables. Creswell (2014) defines independent variables as a probable cause that affects the dependent variable; it is called independent because no other variables influence it in the study.

H5o: There is no statistically improved interventions U.S. hospitals should adopt for the efficient management of cancer patients.

The hypothesis for H5o links to question five and addresses statistical significance based on evidence-based care interventions implemented in the U.S. hospice facilities to improve treatment outcomes and satisfaction among cancer patients. Breaking the barriers to life-and-death discussions in the hospice forum is essential, and from these perspectives, hospice care is a passive form of care when nothing can be done, and there is no hope for survival. A more critical hypothesis for H5o focuses more on the intermediary variable into the explanatory variables that may help explain an event or outcome with the hospice center, comparing the non-profit to for-profit centers. This overall provokes the question of what they need for a better quality of services (Zimmerman et al., 2016).

H6o: There is no statistically significant evidence-based care intervention that has been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients.

The hypothesis H6o follows research question number six. The hypothesis relates to scientific observations to the statistics concerning the evidence-based care interventions implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients. This hypothesis relates to all independent, intermediary, and dependent variables. The hypothesis helped the researcher focus on the data to determine the cost-related access issues that many patients have experienced in recent years (Zimmerman et al., 2016).

H7o: There is no statistically significant relationship linking aggressive symptom management and intense hospice care to providing high-quality hospice care results in low-quality care.

The final hypothesis, H7o, presents question seven’s statistically significant relationship linking aggressive symptom management and intense hospice care to ineffective management issues. This hypothesis, and question seven, stresses the need to restructure and equip healthcare professionals. More importantly, this represents all three variables (independent, intermediary, and dependent variables) in a way that addresses strategy. It helped show comparable outcomes for this study and historical gaps for treatment (Zimmerman et al., 2016).

Hypotheses Testing Alternatives for Phase I

The survey instruments used in this analysis ensured that the data collected met the four measurement scales (nominal scale, ordinal scale, interval scale, and ratio scale) (Tabuena & Hilario, 2021). This ensured that the data met the requirements for the tests mentioned earlier. The immediate advantage of using these scales is that they eased comparing alternative hypotheses and make processing variables convenient. Suppose the data does not meet the requirements for the chosen test. The researcher refocused author White's (2016) null hypothesis rejected concepts and the p-value set to 0.005 or 0.5 percent. This indicates that the null hypothesis or hypotheses testing alternatives can be dismissed even if the error rate was set to 0.005 or 0.5 percent. The p-value for the hypothesis was tested at the beginning of the survey, reported, and available to determine whether the error rate was acceptable with the research methodology.

The researcher executed several scopes of analysis leading to survey questions. Semi-structured surveys utilize open-ended questions to enable data output (Creswell, 2014). The data output enabled the researcher to decide on the ongoing process to collect empirical information. Determining modes of communication (e.g., tests and questionnaires) will entail using standardized inquiries for each participant and consciously avoiding researcher bias (Friesen et al., 2021). Moudi et al. (2020) discussed the standardized process concerning a mixed-methods study and showed how the collection process improved the examination's credibility, validity, and precision. In short, a mixed-method research process integrates various types of data, usually drawn from diverse techniques. As a result, mixed-methods evaluations demand advanced planning and careful management in each stage of the study. The researcher’s planning stage is critical to successful mixed-methods data collection; the research evaluation in deciding the process necessitates a combination of convergent processes (Zhang et al., 2021). These processes and decisions were based on the review's objective of collecting data and the necessary evaluation inquiries. Still, factors such as time and expense must also be evaluated (Wang et al., 2018). The researcher's approach in drafting the data collection entails the Scope of Work (SOW) process, which stresses deciding which questions need rigorous attention (Flick, 2018; Ivankova & Wingo, 2018). In such a SOW process, assessment influence may be attributed to a specific purpose. The evaluation included a practical or quasi-experimental design consisting of a control or comparison group (leadership vs. quality of care for the patient). In effect, the decision process is in the planning stage, so the research design allows for this process of SOW design. The research intention is to answer questions oriented toward the researcher's purpose. The non-experimental procedures or qualitative portion of the study will be sufficient to back the quantitative portion (Creswell, 2014). This is especially true in a mixed-methods study that needs both attribution-related and other types of questions, which may evaluate and incorporate aspects of both experimental (or quasi-experimental) and non-experimental designs (Johnson & Onwuegbuzie, 2004). The planning stage determines that the evaluation demands the mixed-methods process and careful management to accomplish the dual purposes. During the analysis, the researcher will extrapolate collected data by relying on theoretical and abstract information, utilizing routine procedures, analyzing any conflicting points, and recapitulating ideas from each unit of study (Schoonenboom & Johnson, 2017). The researcher explored the research question process systematically (Creswell, 2014). Next, the researcher collected the surveys by email or mail. The researcher enacted data triangulation by utilizing SPSS-28, Cox regression code textual data, manually entering the result into Word and Excel. After reviewing each questions' responses for data saturation and after data examination, the researcher will format each point into an Excel or Word document (Morse, 2012).

Summary of Quantitative Data Analysis

Quantitative data analysis in this study analyzed the numbers-based data – or data collected from the survey that can be easily converted into numbers without yielding the true meaning of the study (Collins, 2010). SPSS analysis software package will be used to help analyze data. This factor is needed to explain the quantitative portion of the analysis, which asks questions on a Likert scale of one to five. Choosing precisely which questions to conduct characteristic research on is both an art and a science. Onwuegbuzie and Johnson (2021) argued that the process has a trade-off between the accuracy of the data and how manageable it is to work with, and that the best solution delivers a simplification that illustrates the true nature of the data, with the lowest loss of preciseness.

Reliability and Validity Phase I

In quantitative research, the reliability and validity of the instrument are essential for lessening mistakes that might emerge from measurement situations in the research examination. Reliability guides the accuracy and precision of the study procedure (Creswell & Poth, 2018). Creswell and Creswell (2017) describe validity as the extent to which an instrument measures the intended behavior, thus permitting the researcher to construct inferences from the instrument.

Reliability Phase I

The internal reliability for this study was measured on the Likert-type scale and was conducted on the results (Creswell & Poth, 2018). This helped assess how well each variable reflects the quality of care and the leadership management needs to improve that quality of care. The correlation between variables was examined based on the correlation matrix of all variables on the scale and the alpha level, as explained by author White (2016).

Validity Phase I

Validity refers to the degree to which a study accurately mirrors or evaluates the distinguishing concept or construct that the researcher is trying to measure (Creswell & Creswell, 2017). Content validity demonstrate the degree to which the survey variables and results are representative of the potential questions about the problem in the assessment of hospice patient experiences with cancer care services in the United States. The internal hospice care validity speaks to the truth of the study itself and demonstrates a causal association between variables, where independent variables are expected to influence a dependent variable (Creswell & Poth, 2018). Furthermore, to help mitigate any dangers that could compromise the research's internal validity, the Research Institution’s medical records and SPSS were used to assist in validating the data collected in alignment with the predefined routines and permissible limits.

Summary of Reliability and Validity for Quantitative

In Phase 1, reliability showed a measurement process within each variable and instrument and shows internal consistency. The researcher showed the process validity to a degree to measure instrument and participant behavior. Both reliability and validity are vital in phase one to establish the significance of findings within this mixed-method study. Each of the survey instruments that will be used in this examination will illustrate reliability and validity. Phase I addressed circumstances associated with reliability and validity and the researcher discussed how any potential problems would be addressed to assure reliability and validity.

Qualitative Analysis Data for Phase II

The researcher utilized the history gap to evaluate each interview for parallels and discrepancies (Saunders & Townsend, 2016). Data within the qualitative portion will be complete when sufficient data are produced within the study, no further details are elicited, or supplemental coding is no longer applicable (Zohrabi, 2013). The qualitative analysis process is vital because it determines whether a study establishes adequate representation to display content validity (Mohajan, 2017). The study called for exactly 96 participants. The representation of the population sample size ensures that findings suggest several factors that influence better data quality in collection, amount and complexity of data collected, sample heterogeneity, and researchers' findings (Collins, 2010; Onwuegbuzie et al., 2018). This factor was required to justify the qualitative portion of the study, which relies on asking questions to acquire data. The sample size must be determined in any mixed-methods study to maintain the aim for the research and theoretical purpose (Onwuegbuzie & Johnson, 2006). Onwuegbuzie and Johnson (2021) contended that the qualitative portion does not happen with supplemental interviews. Instead, the last interviews become more critical for data saturation.

Emergent Ideas for Phase II

Emergent ideas encompass the knowledge, skills, and perspectives that develop during the researcher ‘processes, which are reflective recorded notes on what the researcher discovers during data analysis (Fusch et al., 2017). This process will occur after the questionnaires are submitted and loaded into the relevant software. The researcher will also read the transcribed questionnaires to better understand the participants' responses. Doing so helps manage and organize the data collected (Johnson & Onwuegbuzie, 2004).

The emergent ideas helped the researcher analyze the text and other forms of data that might present a complex process for the mixed-methods design study, such as deciding how to organize the data in tables, matrices, and via narrative structure. The research process involved organizing the data, performing an initial read-through of the database, coding, categorizing themes, illustrating the data, and forming an understanding of the material. These measurements are interconnected and aided in the data processing. The software helped in the mixed-methods data analysis because the programs boost task performance, making the data collection process more convenient and quicker. However, they are not necessary for completion in mixed-methods design (Onwuegbuzie et al., 2018). Patton (2014) notes the function of software in the research approach or collection process, stating that many researchers believe that software offers leaps in productivity for those proficient at it, but utilizing software is not a necessity. In fact, before the computer, many researchers like Albert Einstein produced ideas in their heads; the actual analysis takes place in one's head (p. 530–531).

Coding Themes for Phase II

Data coding is the procedure of classifying words and sentences according to identical substances to create a theme (Taylor et al., 2018). During the collection process, confidential information, such as names, emails, or Internet Protocol (IP) addresses, was maintained by the researcher. Where anonymity is not possible, the researcher took measures to maintain the confidentiality of study participants and the data collected. The researcher took steps by keeping data confidential using standard safeguards, such as substituting codes for participant identifiers and storing data in locked cabinets (Clark, 2019). The researcher utilized a sequence of data collection implementation techniques and deductive and inductive journaling to mitigate bias in the gathered data (Terrell, 2012). This process entailed interviewing each participant and recording the discussion. For the last phase of the deductive and inductive analysis, the researcher will identify the codes and will organize data into themes to gather information (Clark, 2019).

The researcher assigned codes to each theme and participant; Table 1 shows an overall range of themes proposed in the study. This approach provided an automatic convergent parallel to collected data and gave the research a theme. The researcher transcribed the interview recording and notes into research documents and then utilized software to complete a structural coding of the information. The coding looks for similarities and trends for the basis of findings and recommendations.

Interpretations for Phase II

Developing and accessing interpretations demands assigning substance to the gathered data and defining the conclusions, significance, and implications (Taylor et al., 2018). The researcher developed the data analysis as a process of function toward the study design and data collection, however, yielding to the purpose of the study and leading into the survey questions in the hopes that it will provide structure for the findings and give an interpretation that might better help understand the gaps (Johnson & Onwuegbuzie, 2004).

Data Representation for Phase II

The research process for the question and the researcher's interest in the topic is usually one purpose of the research project, but the researcher's goal is to provide concise data (Onwuegbuzie et al., 2018). Table 1 shows the alignment of variables leading into each question.

The researcher focused on the study developments with emergent compositions and relevancy to construct analysis. Table 1 illustrates the relations coded into identifying leading themes and identifying themes in a mixed-methods study (Johnson & Onwuegbuzie, 2004). Researchers reflect on the data process and reporting; however, data collected from multiple questionnaires are required to finish the conclusion. The researcher concentrated on critical themes gathered from the participants' collected responses for analysis and reporting (Clark, 2019).

Analysis for Triangulation for Phase II

Triangulation examines similar results using convergent data collection procedures (Johnson & Onwuegbuzie, 2004). The researcher has three primary concerns: enhancing validity, creating more in-depth knowledge, and creating trustworthiness (Creswell, 2014). The quantitative data for this analysis was gathered anonymously via a secured online survey generated from multiple sources and present and past patients from medical records acquired from the Research Institution organization. The study focused on triangulation and synthesis that interprets data, ensuring a relation between the theme and the decision-making process in the hospice care industry. The expectation is to reinforce the study results with the responses from participants in different positions in various facilities delivering similar results.

Summary of Qualitative Data Analysis

The researcher created a multifold, data-driven data interpretation that demands reflexivity, such as awareness. The method was required to recognize bias, understand the process of evidence, and negotiate further challenges to the emergent approach. The researcher scrutinized the data gathered and utilized the findings to ensure that the concept will generate truthfulness. Using a data analysis, a summary shows that the adequate research size enabled the researcher to evaluate the overall significance of the findings (Aron & Aron, 1997, p. 137). The researcher administered each interview question. Qualitative research used multiple data collection sources to support the study's validity. The qualitative phase consisted of two semi-structured interview questions, allowing the participants to freely discuss necessary points concerning the topic.

Reliability and Validity Phase II

A mixed-methods study is essential for the progression and for preparing and compensating for the study; for example, any developing weaknesses within the study that might need a strengthening approach (Onwuegbuzie & Johnson, 2006). Reliability and validity permit the researcher to see themselves as part of the study (Creswell, 2014). The researcher must consider reliability and validity when planning and evaluating the collected data before constructing any conclusion. Doing so helped resolve any concerns with reliability and validity and assisted in meeting measures of the quality of the study, thus giving consistency to the measurement or trustworthiness of the survey (Hulme et al., 2021).

Reliability Qualitative Phase II

Reliability explains the designated purpose of the study and helps to predict and generate processes in any investigation. This promotes rigor and trustworthiness to attain credibility, transferability, dependability, and confirmability (Hulme et al., 2021). Forbes et al. (2021) noted that the goals in designating reliability in studies is to help to promote trustworthiness and ensure the results in a mixed-methods study. Many researchers process the aligning research questions in the same directive for each participant during data collection. One method for researchers to exhibit reliability in the study is to assure the investigation can be duplicated or disseminated;

this includes consistently checking the data process to ensure that the proper process is being implemented (Shen et al., 2021).

Interview protocols were employed to form a reliable study. The interview technique and process were not impacted by bias from the researcher. The uniform structure followed the Belmont guidelines. The researcher developed and relied on the interview guide to improve consistency in reliability. The Belmont guidelines equip the researcher with a framework to enhance consistency when questioning participants (Romm et al., 2018). Kyngäs et al. (2020) utilized the interview compass to enhance credibility by supporting individual participants and researchers in interview questions. Campbell et al. (2020) characterized reliability as a convergent process of exploration in allowing the researcher to triangulate the data to enhance the conclusions. The researcher deployed these efforts to increase reliability, expand the study's knowledge, and identify future gaps in the performance of the study (Onwuegbuzie & Johnson, 2006).

Validity Phase II

The researcher established validity in this research by exhibiting integrity and employing ethical procedures and accuracy in interpreting the data findings (Vilma, 2018). To ensure validity, the researcher connected the elements of the analysis, such as past literature, study questions based on data collection procedures and examination, and research findings (Maggio et al., 2020). The researcher utilized convergent parallel and triangulation synthesis to further secure this study’s validity. Validity must also include the transferability process in a mixed-methods study (Onwuegbuzie & Johnson, 2006). Guest et al. (2012) pitched this idea by defining transferability as study trustworthiness that must show credibility, reliability, and confidence.

Pandey and Pandey (2021) defined validity as a procedure that links findings to conclusions so that other scholars can follow and duplicate the study. The researcher used software to accomplish validity and identify routines, including characteristics of patient dissatisfaction or leadership planning for improvement. This process allows study of a statistical approach and shows the consequence of several risk factors on quality of care or specific circumstances to improve better leadership. To enhance validity, the researcher utilized member checking to affirm accuracy and allow participants to ensure that they understand the findings of the study (Onwuegbuzie & Johnson, 2006, 2021).

Bracketing Phase II

The researcher employed descriptive bracketing to address bias and anticipated themes. Additionally, the procedures highlight the qualitative phase and the process (Onwuegbuzie & Johnson, 2021). Gearing (2004) called this the mixed-methods processor mapping the proper theoretical and philosophic reinforcements of bracketing that will enable identification of core components that compose bracketing and distinguish the research strategies that prioritize different bracketing components.

Different methods for bracketing contain or mitigate biases in research, but more importantly, when a single process is used, the cognizing process only benefits expanding research techniques that are rooted in one tradition, which involves the researcher not bracketing past knowledge and being sensitive to the quantitative portion of the study (Mayoh & Onwuegbuzie, 2015). Bracketing is a critical process in the mixed-methods process that helps control the theme, thereby permitting the researcher to facilitate new knowledge concerning the examined phenomenon (Levitt et al., 2017). According to Tavakol and Sandars (2014), bracketing is a process that requires an appropriate inquiry approach, and a basic understanding of how quantitative and qualitative methods contribute to a phenomenon. The challenging component of managing biases is bracketing requires setting aside personal preferences. This process employs journaling and examining personal biases throughout the study (Onwuegbuzie et al., 2018).

Summary of Reliability and Validity Phase II

Reliability and validity highlighted the study' importance and indicate the study's effectiveness and quality. Reliability develops the theme endorsed by the validity process in collecting the data and can be reproduced by other scholars. The means and the approaches summarize the objective of the research project. The researcher employed these means to demonstrate reliability and validity by utilizing reliability, credibility, truthfulness, and data saturation. The researcher's goal applied research methodology to develop new knowledge that can be incorporated into the study of hospice care management. Satisfying this objective will expand current knowledge**.**

The research design focused on a mixed-methods approach to help investigate how the administration of hospice leadership can lead to the bettering of quality of care. This section summarizes the function of the researcher, participants in the examination, the research procedure and structure, population and sampling, data collection, data analysis, reliability, and validity of the study undertaking. The researcher utilized the study procedure outlined in Sections 1 and 2 to perform the research in the hopes of adding to the current knowledge or gaps in the knowledge through interviewing participants.

Summary of Section 2

Section 2 begins with a reiteration of the study's purpose and the role of the researcher. In the progression of patient care, it is essential that services in hospice centers be dedicated to the patients' physical and emotional well-being to enhance their quality of life and lengthen their lifespan. The study’s focus is recapped, and detail is provided on the overall objective of this research: assessing hospice patients’ experiences within the United States. The role of the researcher in mitigating bias was discussed in detail and included elements related to the Belmont policies of beneficence and justice and gaining IRB approval before data collection begins. The general procedure was described for obtaining informed consent from each potential participant. A discussion of bracketing as a means of diminishing bias was provided. The research methodology section described the design and methodology that was utilized in this study and provided a process to investigate the relationships, if any, between a hospice patient’s experience with cancer care services and management's failure to provide high-quality cancer care, resulting in quality control issues and customer dissatisfaction among cancer patients. The study was designed to develop the existing literature and explore the quantitative variables related to assessment in hospice care, leadership management, and quality of care in hospice healthcare. The section was finalized with an assessment of the study’s population and planned sampling techniques, and a description of the data collection and analysis procedures. A discussion was presented to define and examine the relationship between assessment in hospice care, leadership management, and quality of care in hospice healthcare. Finally, reliability and validity processes were provided to show how the researcher ensured trustworthiness in the study, including credibility, confirmability, bracketing, and data saturation. Section 2 concluded with a review of how reliability and validity was ensured in the present study.

Section 2 provided an overview of the mixed-method design, broken into the study's Phase I (Quantitative), Phase II (Qualitative) procedures and design approaches. The objective of this study and the research questions that were formed were utilized to navigate the techniques employed below. The interview guidelines (Appendix A, B, C, and D) depicted the data collection process for both study designs. Phase I (quantitative) accumulated statistics from the gathered data to help fulfill the problem's parameters. These parameters focused examinations on critical issues in healthcare organizations to create a reliable foundation for future research and will utilize necessary material and literature reviews. Future research might illustrate the experimental implementation of quantitative techniques to enhance the planning and hospice care system around the United States.

Phase II (Qualitative) used unstructured and non-numerical data by employing the historical empirical archive. The use of unstructured design includes open-ended questions and consolidated data, including field notes, observation, interviews, questionnaires, and literature. This portion of the study establishes and closes the gaps in prior literature and responds to the decision-making process that combines the mixed method with a convergent parallel. It also may help future studies close the gaps and supports the interview protocol and procedure. This process helped the convergent parallel design sampling led to two types of questions, quantitative and qualitative. In the operational process of the research questions, a literature review may be the best methodological tool to provide answers in a mixed-method design.

Overall, Section 2 provided an in-depth summary of the project, commencing with the purpose statement and the role of the researcher, including ethical considerations in the study. Section 2 reviewed the procedure of obtaining participants, including strategies for securing informed consent and protecting participants. A review of the sampled population and sampling methods came next. Data comprises the following sections, including the data collection procedure, a review of the data organization procedures, and the data analysis process.

Finally, there was a discussion on how the researcher ensured the reliability and validity of the study.

Section 3 begins with an overview of the study and the presentation of findings. Section 3 provides applications to professional practice and recommends areas for future research. Section 3 culminates in a reflection on personal growth and includes a biblical perspective.

Section 3: Application to Professional Practice and Implications for Change Overview of the Study

The purpose of this mixed-method study was to address management's failure to provide high-quality cancer care in hospice healthcare facilities in the United States, resulting in quality control issues and customer dissatisfaction among cancer patients (Marzal-Alfaro et al., 2020; Tandon et al., 2020). Mixed methods research (MMR) is an adaptable and practical design for studying myriad topics in health administration, thus creating pathways of exploration for this study of hospice care in the United States. MMR is frequently used in the realm of health services management research; however, few studies have addressed the failure of management to provide high-quality hospice care in healthcare facilities. Failure to provide high-quality care leads to issues with quality control and customer satisfaction in hospice centers (Jacobs & Shulman, 2017; Osagiede et al., 2018; Pesut et al., 2020).

The researcher applied an MMR design to conduct a systematic survey with 96 participants in select U.S. based health services management facilities. Medical records between November 2022 and March 2023 from the Research Institution organization were used to select participants for this study. The first phase of this study included surveying participants by using questions that yielded quantitative responses. The second phase involved a systematic qualitative procedure using (a) the internet, (b) telephone communications, and (c) email correspondence.

Extant research was analyzed as well by using a qualitative method to further explore the subject of hospice patient experiences based on the research questions.

Thus, this analysis linked interview questions with hospice care providers and the patients whom these providers serve. This study aimed to evaluate the possible failure of management in hospice healthcare facilities in the United States to provide high-quality cancer treatment, which often leads to quality control and patient discontentment issues (Marzal-Alfaro et al., 2020; Tandon et al., 2020). The MMR design for this research included interviews with patients and their family members, as well as facility staff and stakeholders with prior experience in hospice care. Specifically, the medical records data from November 2022 to March 2023 from the Research Institution organization included participant interviews with family members who lost relatives to cancer between 2010 and 2021. The research concept adhered to the positivist philosophy while incorporating concurrent qualitative methods to achieve the exploratory aims (Dawadi et al., 2021).

The researcher followed the model proposed by Abraham Maslow (Dohlman et al., 2019) which suggests that people have progressive needs and goals beginning with basic physiological requirements such as food and shelter, and then progress to feelings of safety and security, esteem, and eventually self-actualization. For instance, some of the patients in this study who received hospice care at home were prescribed medication for pain relief. Relating to Maslow’s hierarchy of needs, pain medications were prescribed to alleviate the patients’ suffering as a natural human goal. In contrast, patients in this study who had inpatient hospice services and did not receive pain medication might have reported increased patient dissatisfaction toward the administration and leadership of the hospice facilities.

Maslow’s (Dohlman et al., 2019) theory served as a starting point for this research inquiry. Three variables were considered related to hospice cancer patients’ hierarchy of needs: (1) hospice care itself was the independent variable; (2) leadership management served as an intermediate variable; and (3) patient quality of life (QOL) was the dependent variable (Ventegodt et al., 2003). These variables provided focal points for the research by relating to the general problem statement that addresses the potential failure of management to provide high-quality hospice care in healthcare facilities, resulting in quality control issues (QCI) and customer dissatisfaction within hospice centers. The review of the literature revealed that few studies have focused on failed efforts, specifically by hospital management, to provide high-quality hospice care: this study aimed to provide answers in the interests of patients and medical leadership.

A systematic survey was performed utilizing terms such as “hospice management”, “quality of life”, and “honoring the patient's end-of-life wishes”. These subjects were the main focal areas of the interview. The study interview took place with 96 participants, and questions and surveys were administered to all participants. The researcher spoke with 15 participants via telephone, 12 participants in person, and 69 via email for the conduction of interviews. To complete the quantitative portion of the survey, responses were entered into the Morgan and Leech SPSS software for Basic Statistics. The NVivo program was used to complete the qualitative portion of the survey. Following a thorough analysis of the survey responses for the quantitative components, as well as a comparison to findings in the literature, six conclusions were extracted as significant takeaways from the study. The researcher drew conclusions from the results about the relationship between leadership management and the quality of hospice care provided in healthcare institutions in the United States. Via the hypothesis, the researcher analyzed the quantitative responses from Phase 1 of this study using concepts that corresponded to the fundamental research question. Additionally, the researcher investigated the statistically significant relationships that demonstrated management's failure to provide high-quality hospice care, which led to QCI and customer satisfaction concerns (Pesut et al., 2020). For ease of analysis, quantitative and qualitative research questions were distinguished as follows in relation to the null (H_0) and alternative (H_a) hypotheses: questions 1, 4, 5, 6, and 7 were quantitative in nature, whereas questions 2 and 3 were open-ended and qualitative. The researcher examined the data to test and evaluate the degree to which these factors were associated with specific results. The study results suggest improving leadership and administration of healthcare institutions in the United States and addressing the quality of hospice care available to cancer patients. Participant responses to interview questions were used to develop a concept matrix shown in Figure 1. In addition, Tables 2 and 3 display results for the quantitative Likert scale responses.

Figure 1 displays the components of Maslow's hierarchy of needs theory to help analyze the leadership management concepts and plans that were implemented at each hospice center and outpatient services across the range of questions one through seven. The group of questions focused on experiences with hospice patient care methods and assessments, as well as first-hand patient accounts on treatment quality and ways to improve it. On a scale from 1 to 5, the questionnaire asked respondents to rate how strongly they agreed or disagreed with statements. The researcher asked seven questions, five of which were quantitative and two of which were qualitative. Each quantitative item allowed for conversion of the survey question into a statistical dataset.

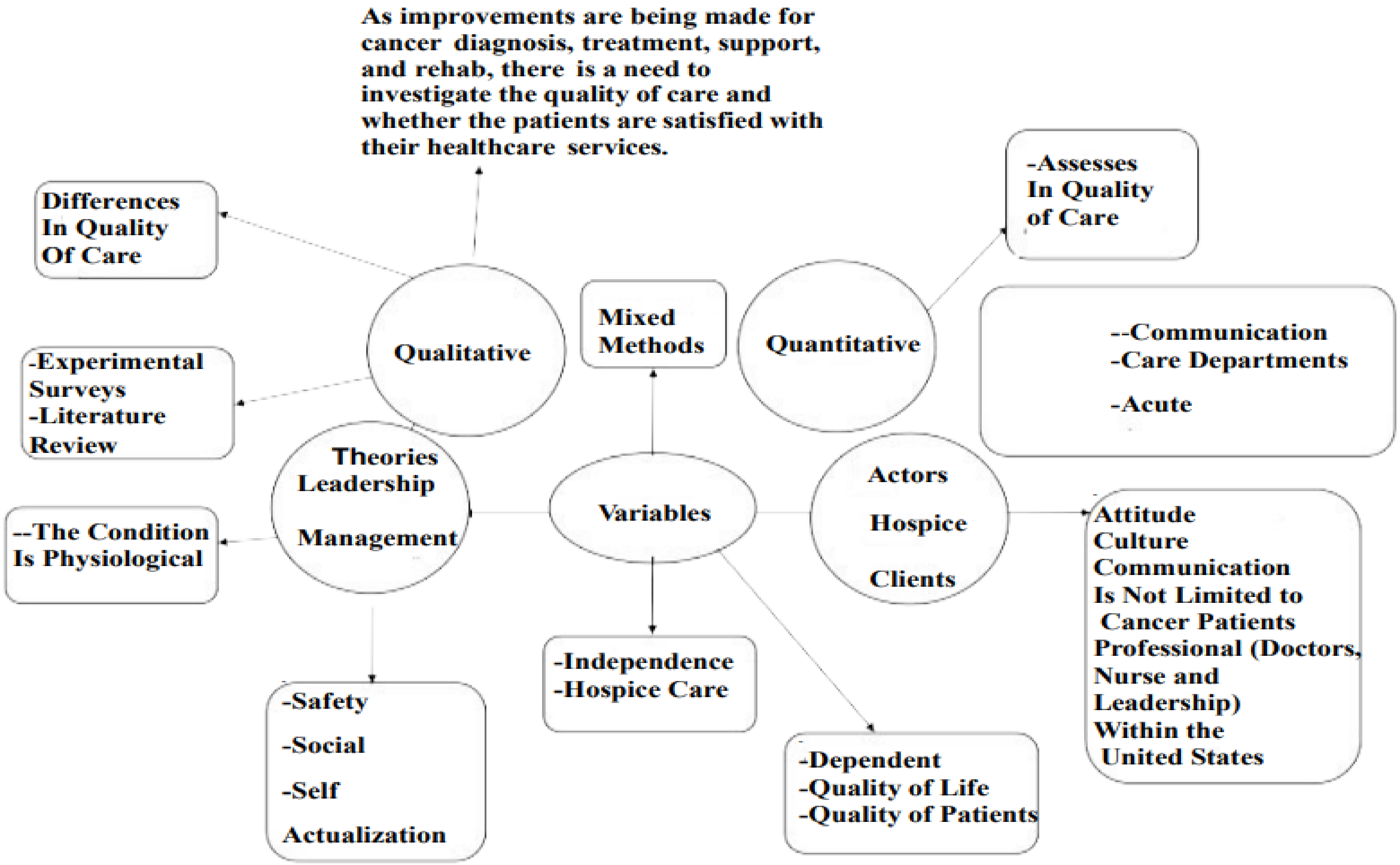
The study findings have the potential to give a remedy for the problem of the inability of management to provide high-quality hospice care that mitigates repeating issues that play a role in detecting adverse conditions. The findings may enhance the quality of patient care and may help improve patient satisfaction. Researchers and grant makers who give guidance for providing end-of-life care, and other hospice program directors may find the outcomes of this study beneficial for planning purposes. The study focused on and followed guidelines that meet the U. S. Department of Health and Human Services (HHS), and the study's purpose was to follow the standards of other hospice institutions and stakeholders (The U.S. Department. of Health & Human Services, 2023). Finally, the implications of the results on leadership management and quality of care (QOC) in healthcare institutions in the United States gives hope toward closing critical service gaps in the hospice industry.

Integrating qualitative and quantitative research approaches into a single inquiry or a conjoined set of investigations is the central tenet of the MMR approach (Dawadi et al., 2021). The methodology proposes that the most valuable aspects of the two different techniques be combined. This research employed MMR to address the nature and outcomes of hospice care for cancer patient in the United States. By including theme discovery from interview responses, this MMR study produced reports of important human experiences which might enable researchers to gain a complete picture of the health status of patients and the QOC provided to them towards the end of their lives. The researcher accomplished a valid MMR inquiry by combining these two types of reports.

This MMR study allowed a deeper exploration of the challenges involved in implementing hospice care through current healthcare systems. Results of this research may assist leaders, managers, and providers with delivering effectual hospice care. According to Whites (2016), mixed methods studies are beneficial for examining various problems related to complicated therapies. These problems include issues related to (a) ineffective symptom management strategies, (b) failure on the part of management to provide high-quality, (c) customer dissatisfaction within hospice centers, and (d) lack of psychological and spiritual support for patients. MMR may provide evidence not only for the efficacy of interventions, but for implementation processes and patient and family responses to treatment. During 96 interviews, the participants in this study provided consensus on a list of suggestions for providing quality hospice care services.

Figure 1

Maslow's Hierarchy of Needs Combined with Leader Management Theory



Presentation of the Findings

Descriptive Statistics for Phase I Quantitative

The researcher calculated descriptive statistics to analyze and characterize the quantitative data from the field study. Specifically, the quality of treatment provided by the responders and the professional level of the participants were included in the analysis of variance (ANOVA) to determine whether these factors had any influence on the outcomes most important to the study. The underlying result was that effective leadership management methods impacted the QOC provided at hospice institutions throughout the United States. Additionally, a significant association between the interventions for quality improvement and the quality of the interventions themselves was connected to the interaction between the care demands and satisfaction of cancer patients. It was shown that significant correlations existed between management affirmations and positive, relevant relationships that linked aggressive symptom control. Furthermore, the link between (a) the care demands of various cancer patients, (b) patient satisfaction, and (c) the dependability of data that demonstrates the success of internal control is a critical management challenge that influences the quality of hospice care.

The issue that prompted this research was the clear need to investigate the appropriateness and sufficiency of hospice care for cancer patients in the United States. As recognized by other research (El-Jawahri et al., 2021), this study showed cancer patients' requirements demand an efficient hospice management system along with quality assurance measures. More specifically, efficient, and quality-checked hospice care, and leadership were identified as necessary factors for effective patient services within the accumulated literature. For instance, nurses are in crucial positions to enhance the quality of hospice care by implementing interventions and strategies for patient safety. Responses from administration and patients in this study contributed to the formation of this conclusion. The applicability of this research is vital, and the results apply to professional practice regarding administration and standards of care.

Furthermore, the results of this study connect with the literature on management challenges, such as growing healthcare expenses and staffing concerns, which in turn impact the hospice patient experiences (Marzal-Alfaro et al., 2020; Tandon et al., 2020). Thus, the research questions included in this study were selected as a means of narrowing the scope of exploration to concentrate on certain management challenges that impact the hospice experience for cancer patients. The researcher, therefore, created a list of variables that highlighted management problems likely to have an impact on patient care and hospice experiences (Swenson, 2022).

The data from the research did not include any outliers that might have swayed the path the investigation followed in determining the direction of the association between the variables. The research was directed by the psychometric measurement properties embedded within the questions targeting the quality of patient care and leadership management framework. This included the analysis of critical factors that may affect the sufficiency and appropriateness of leadership evidence. For instance, these components included corporate management, which is related to the presence and efficacy of internal management tendencies to provide better working hours for employees which indirectly improves the patient's experience. The researcher devised a method of assessment for the purpose of determining how effective management and leadership was exercised. This method considered safety, social, and self-esteem factors, which were identified as variables in this study (Onwuegbuzie et al., 2018). It also provided consistency for the research instrument which aimed for construct validity by measuring QOC through five research questions discussed in Section 1 of this study.

The research instrument for this study achieved the researcher’s goal of measuring hospice patient QOC for cancer in an objective and quantifiable fashion. Each survey question response contributed to the findings offered in this section. The researcher again determined whether or not there was a correlation between the findings and the previous body of literature. Participants were chosen for the study by using a purposive random sampling process. The participants had either been employed as an external member of the United States health system or were participating in hospice care services within the network of the Research Institution organization. Also included as participants were those working in healthcare, leaders in the field, and institutional hospice patients. The data period for this study was the years 2022–2023. The medical records of the Research Institution organization contained a collection of 1,300 samples and was a viable source for random sampling. The sampling procedure further aided the researcher to meet the study requirement sample of 96 first-reach participants.

According to Onwuegbuzie and Johnson (2021), randomly selecting samples creates a subgroup that allows the statistical population to function in a manner in which people from each subgroup have an equal likelihood of being selected. Creswell et al. (2018) further stated that the qualities constituted in a population's larger subgroup may make members of the group more likely to be selected at random, whether or not each member of the population is aware of their precise selection probability. In this study, a simple random sampling method was used to collect data from 96 participants across both sexes. This sample size was determined to be effective using a confidence level of 94.5 based on the population of 1,300 people and using a margin of error of 5%. The following research questions and associated survey items represent some of the more pertinent inquiries made to investigate the issues discussed above. These are followed by descriptive statistics for the entire study as shown in Tables 2, 3 and 4.

Table 2

The Likert Scale Responses

Question	**1** **Very Good**	**2** **Good**	**3** **Satisfactory**	**4** **Somewhat Satisfactory**	**5** **Very Unsatisfactory**
RQ1.	35	6	9	1	42
RQ4.	63	9	15	7	1
RQ5.	85	8	1	1	1
RQ6.	47	7	39	3	0
RQ7.	43	4	1	4	44

Table 3

Question Seven Likert Scale Response

Question	**1** **Not at All Influential**	2 **Slightly Influential**	**3** **Somewhat Influential**	**4** **Very Influential**	**5** **Extremely Influential**
RQ7. To what extent do you feel management issues influence the quality of hospice care for cancer patients?	3	5	7	34	37

Quantitative Survey Questions Relating to Research Questions

RQ1. What are the key management issues affecting the quality of hospice care for cancer?

- How would you rate where your hospice care was delivered on a scale of 1 (*very good*) to 5 (*very unsatisfactory*)?

RQ4. What is the relationship between care needs for different types of cancer patients and patient satisfaction?

- How satisfied were you with the type of cancer services you received on a scale of 1 (*very good*) to 5 (*very unsatisfactory*)?

RQ5. What improvement interventions should U.S. hospitals adopt for the efficient management of cancer patients?

- How important are performance indicators in the efficient management of cancer patients on a scale of 1 (*very important*) to 5 (*not important*)?

RQ6. What evidence-based care interventions have been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients?

- How important are evidence-based guidelines and protocols to you in getting hospice services on a scale of 1 (*very important*) to 5 (*not important*)?

RQ7. To what extent is there a relationship linking aggressive symptom management and intense hospice care in providing high-quality hospice care or resulting in low-quality care and management issues?

RQ7E. To what extent do you feel management issues influence the quality of hospice care for cancer patients on a scale of 1 (*not at all influential*) to 5 (*extremely influential*)?

Table 4

Research Descriptive

RQ	N	Minimum	Maximum	Mean	Std. Deviation
RQ1. What are the key management issues affecting the quality of hospice care for cancer patients?	96	3.00	5.00	4.4063	.62539
RQ4. What is the relationship between care needs for different types of cancer patients and patient satisfaction?	96	4.00	5.00	4.6667	.47388
RQ5. What improvement interventions should U.S. hospitals adopt for the efficient management of cancer patients?	96	3.00	5.00	4.1458	.68023
RQ7. To what extent, if any, is there a relationship linking aggressive symptom management and intense hospice care to provide high-quality hospice care results in low-quality care and management issues?	96	3.00	5.00	4.0208	.79444
RQ7E. To what extent do you feel management issues influence the quality of hospice care for cancer patients?	96	3.00	5.00	4.1979	.69008

Respondents Profiles

Before starting the survey, the researcher asked participants to respond to the following question: "What was your gender at birth” To categorize their responses, the researcher reviewed patient medical histories for congruence, as well as current areas of vocational specialization for the participants who were medical professionals (i.e., nurses, doctors, and leaders). The researcher then utilized the results for the vocational category to check that responses were gathered explicitly from experts at the time of the study, in particular those knowledgeable about the independent, intermediate, and dependent variables. This study was carried out using the responses of leaders only. Thus, 96 individuals were surveyed based on their responses compiled from 1,300 pieces of data.

A total of 42% of respondents identified as male at birth, whereas 58% identified as female at birth. Regarding survey completion, the age groups composed of females contributed the most substantial number of replies. Age groups comprising the whole sample were distributed across two ranges, mostly including 23–67 years of age, while a second, smaller number of respondents—constituting 21.9% percent of the participants—were between 39–59 years. The participation rate across all patient quality survey categories was 69%, which is a remarkable response rate. The respondent group that might be categorized as patients comprised the most considerable portion of the sample. The individuals who would be considered for leadership roles included 10 doctors and 17 nurses, equivalent to a total of 28.5% of all the different participant groups. Finally, 23% of the medical professionals were first responders.

Hypotheses Testing Phase I Quantitative

As aforementioned, SPSS was utilized to determine whether or not there was a correlation between the variables by associating coefficient connections and analyzing the percentage of the variance accounted for by each of them. Namely, a multiple regression (*R*) analysis was completed to identify not only correlation between the variables, but also to explain the variability caused by them so that leaders in the hospice industry may better predict which interventions are most important to patient QOC. To establish whether the results were statistically significant at a confidence level of 95%, the researcher further analyzed the statistical significance of the findings using the *p*-value of .05 as the industry standard. To extract the conclusions of the research based on the research questions, the researcher first identified the demographic profile of the survey respondents, and then mapped the outcomes of the reliability tests that were conducted: these will be discussed in the following paragraphs.

The statistical software program, SPSS, was used to quantitatively analyze the replies of all 96 respondents for correlation and predictability as shown in Table 5. Reliability testing was also needed for the medical information of the patients who participated in the study and is shown in Table 6. To evaluate the reliability of the findings gathered from the collection of patient records from the Research Institution organization across hospitals in the United States, the researcher carried out a supplementary chi-square statistical analysis. The chi-square distribution was successfully applied during the reliability test and demonstrated that the assumption of constant failure rate for this data set was validated. This revealed the trial had a positive outcome. In the case of an exponential distribution, the mean time to failure (MTTF) is determined by taking the inverse of the parameter and calculating the resultant value.

Table 5

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.178[a]	.032	.021	.61872

Note: Predictor (constant) reflecting the assessment of patient need in cancer care contributing to QCI and patient satisfaction.

Table 6

Coefficients

	Unstandardized Coefficients		Standardized Coefficients		
Model 1	B	Std. Error	Beta	t	Sig.
(Constant)	3.313	.628		5.272	.000
The assessment of patient needs in cancer care contributes to quality control issues and patient satisfaction.	.234	.134	.178	1.750	.083

Note: Dependent variable reflecting the key management issues affecting the quality of hospice care for cancer patients.

The researcher used the connection between the management leadership process at hospice facilities, the Gamma distribution, and the chi-square distribution to illustrate why the latter was employed in this study. White (2016) proposed that a value of 0.5 is considered to be acceptable. This research also considered the hierarchy of needs proposed by Abraham Maslow about the progression of people's needs and goals, beginning with basic physiological requirements such as food and shelter and progressing through feelings of safety and security, esteem, and eventually self-actualization (Dohlman et al., 2019).

Three variables were taken into consideration for this study: (a) an independent variable of hospice care, (b) an intermediate variable of leadership management, and (c) a dependent variable of QOL for patients (Ventegodt et al., 2003). Throughout the investigation, these subjects function as focal points for scholarly attention. The purpose of this study was to investigate how well cancer patients are managed in healthcare institutions in the United States. This necessitated assessment of the level of hospice care available in the facilities where patients were served. The study was guided by a total of five questions and subsidiary hypotheses. For instance, as part of the investigation into the core questions. The researcher developed five hypotheses as well as null hypotheses based on the preliminary analysis as listed below:

H1a: There is a statistically significant key management issue affecting the quality of hospice care for cancer patients.

H4a: There is a statistically significant relationship between care needs for different types of cancer patients and patient satisfaction.

H5a: There is a statistically significant improvement intervention for the efficient management of cancer patients?

H6a: There is a statistically significant evidence-based care intervention that has been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients.

H7a: There is a statistically significant relationship linking aggressive symptom management and intense hospice care to providing high-quality hospice care results in low-quality care.

The hypothesis testing and prediction prototype did not remove an outlier variable from the study variables. The researcher found that the prototype examined was a statistically significant prediction benchmark for reported leadership management for patient quality. The findings support the study problem and purpose. The researcher considered the existing literature to specify and evaluate any potential investigations of the statistically significant relationships that show management's failure to provide high-quality hospice care, resulting in quality control issues and customer satisfaction (Pesut et al., 2020).

Analyzing the survey instrument using the chi-square test of independence provided helpful information for improving patient flow by investigating the connections between the variables (White, 2016). In accordance with what is shown in Table 1, the chi-squared statistics expressed as χ^2 are what created the variables for each research topic. The researcher anticipated that there might be a connection between the need for leadership and provision of superior care to patients. The chi-square evaluated the null hypothesis relating to hospice services for improved quality and examined the status of the independent and dependent processes and overall aids in deciding whether the association was significant. The researcher once again applied a *p*-value of .05 before the hypothesis was tested (White, 2016).

The researcher first established a quantitative research strategy to analyze the variable and answer the research objectives. The absence of leadership management at hand alongside QOC viewpoints indicates that evidence gathered concerns management challenges in hospice sectors. Restrictions in the management approach also led to concerns about patient care, and nurse and physician burnout. This research study on hospice care in the United States has the potential to stimulate trust and reduce worry about the authenticity and reliability of procedures in U.S. hospitals. The recurrence of mismanagement failures indicated that leaders may sometimes face confines that they are unable to manage when bridging the gap between QOC and management.

The quantitative strategy applied allowed the researcher to collect replies from five nurses and eight physicians to understand major professional categories relating to the independent, intermediate, and dependent variables. The responses gathered from these respondents of the targeted medical population gave information on the influence of introspective factors common to nurses and doctors of cancer patients in hospice**.** The statistical analyses performed on the data gathered were given a second look to establish whether or not the hypotheses being investigated were supported and verified by the responses of the respondents and the recorded data. Further analysis of the hypotheses demonstrated a sufficient and adequate link between improved QOC and unhappy patients, and this relationship correlated to leadership management and had a substantial influence on the other variables and elements under study. The researcher used the assessment results to validate conclusions or implications for the practice of the hospice business or suggestions for board members and found that a crucial recommendation is to close the gap between hospice leadership and the level of care provided. A portion of this recommendation pertains to the importance of establishing a relationship between patients and supervisory administration. The patient services function of care provision requires necessary reinforcements from leadership and in return serves as an early cautionary system for oversight to assist in addressing facility or management limitations.

The Subject Population and Various Methods of Sampling

Ashworth (2003) evaluated the usefulness and importance of selecting participants who grasp the phenomena being investigated and understand how it might add to a given field. In agreement with Ashworth (2003), the researcher chose qualified, voluntary participants based on the criteria of having had interactions with nurses, doctors, and leadership participation in the hospital context. The researcher's intent was to achieve the study aims of attaining in-depth information relevant to cancer patient experiences in hospice. Therefore, participants were categorized as belonging to one of two groups: (1) Hospice care leadership from centers throughout the United States willing to participate in the study, or (2) Hospice patients between the ages of 18 and 65 years.

By incorporating specific selection criteria, the researcher was able to develop and complete this study. Using the patients' medical records, the researcher was able to design and conduct the study so the results may be shared with the Research Institution organization. The researcher selected patients who received hospice care for extended periods and were willing to talk about their experiences with management, nurses, and doctors. The researcher believes the results of this study will be of value to stakeholders at the Research Institution organization who are concerned with hospital leadership and patient care.

Probability Of Type I Error

From the beginning of the research method, the researcher developed a benchmark for the null hypothesis by using author White's (2016) aspect of setting an α of 0.05 to indicate that the researcher recognizes a 5% probability that the conclusion is inaccurate when the null hypothesis receives rejection. White (2016) also asserted that the null hypothesis is the claim that there is no impact on the population sample. Author Tan (2020) talks about the sample in providing sufficient evidence against the claim that there is no effect on the population ($p \leq \alpha$). The setting α of 0.05 was important in this study, defined as type I error alpha (α), which was the degree of significance in assessing the hypotheses.

The current study focused on data collected on five survey questionnaires as the sample for the hypothesis tests. For example, clinical trials strive to identify the effectiveness of new treatments or drugs through a hypothesis test. The standard strategy for determining if the new treatment or drug is effective compared to the status quo treatment or drug is null hypothesis significance tests which utilize the p-value to assess the statistical significance of the conclusion

(Albuquerque et al., 2022). Kalpande et al. (2023) hypothesized that employing a decreased α coefficient is essential to reducing type I error risk. However, using a decreased alpha value indicates that the investigator may have a restricted likelihood of recognizing an existing disparity in the information if one emerges. However, since the researcher followed White's 2016 degree of significance in assessing the hypotheses, it gave the results a higher degree of outcomes.

Probability Of Type II Error

Kalpande et al. (2023) asserted that when the null hypothesis stands incorrect, and the investigator fails to reject the null hypothesis it creates a type II error. In this circumstance, the possibility of committing a type II error is equivalent to one minus the power of the test, which is called beta. The power of the examination could be expanded by growing the sample size, which diminishes the risk of engaging in a type II error. The researcher ensured the sample size (1300 respondents) and randomly picked 96 participants, which were sufficient to identify a relevant distinction if a type II error transpired. Thus, type II error is marginally present and needs to be more robust to affect the study results provided by the extensive, selected sample (Kalpande et al.,2023).

Summary of Hypotheses Testing

The hypothesis testing determined the study had three variables: (a) an independent variable of hospice care, (b) an intermediate variable of leadership management, and (c) a dependent variable of QOL for patients (Ventegodt et al., 2003). The hypothesis findings were confirmed and clarified by the test outcomes. These outcomes show the hierarchy of needs proposed by Abraham Maslow about the progression of people’s needs and goals, beginning with basic physiological requirements such as food and shelter and progressing through feelings of safety and security, esteem, and eventually self-actualization (Dohlman et al., 2019). The test outcomes revealed that when looking at the adequateness and suitability of the link between improved QOC and unhappy patients, this relationship correlated to leadership management and had a substantial influence on the other variables and elements under study.

Relationship of Findings Phase I

The management of hospice care is a complex and challenging endeavor; it requires organizing a steady supply of solace and assistance to terminally ill patients and their families, as well as effectual communication, direction, modeling, and training to staff. Furthermore, the provision of hospice care in the United States often depends upon several different methods, including a multidisciplinary team approach, inpatient and outpatient hospice care, pain treatment, and psychotherapy.

This study of the administration of hospice care in U.S. hospitals addressed problems such as patient and family satisfaction, QOC, cost-effectiveness, and staff management. The researcher utilized a mixed methods design that included questionnaires and a survey. Studies like this one play crucial roles in the effort to increase understanding about the most effective ways to achieve the goal of quality hospice care management, which is to improve the QOL for patients and their families during the end-of-life journey. The purpose of this study was to assess hospice care management for improvement of services and the QOL for patients and their families during late-stage cancer. The administrative goal of hospice care during the dispersion of duties should be to enhance patients' QOL at a minimum. Additionally, this study focused on how the administration of hospice care in the United States is constantly changing to meet the shifting requirements and preferences of patients and their families, including their financial security or lack thereof. A secondary purpose of this study was, therefore, to help ensure that all patients receive the highest QOC possible during their final days.

To this end, one example of a developing pattern in this study, discussed under the Emotional Support theme, was the tendency towards using new technology, such as telemedicine and wearable gadgets to manage hospice care. These technologies make it possible for staff to (a) monitor patients more efficiently, (b) communicate more effectively with one another and patients, and (c) include patients and their families more actively in the treatment process. This was, therefore, a positive finding for patients and staff receiving or administering hospice care.

Another vital outcome of this study for hospice care patients nearing the end of their lives was the need to ensure that they receive services that respect their culture and ethnicity. Several studies have shown that people of minority groups are less likely to obtain hospice care and are often ignored. This is especially true in the United States (Kogan et al., 2023). The administration of hospice care must take these disparities into consideration and make it feasible for all patients to get high-quality hospice care customized to their needs and the cultural norms they were raised with.

Another point to consider from the findings of this study is the obligation to cater to the needs of the workforce that provides hospice care. Discussed under the Burnout theme, the obligation to support staff falls within the purview of the administration of hospice care centers. Volunteers, social workers, chaplains, and nurses are all examples of potential members of the hospice care profession—however, nearly 100% of the administrative participants interviewed mentioned occupational stress, such as anxiety and turnover, which lead to staff burnout. Several prior studies suggest that high levels of occupational stress, turnover rates, and burnout among hospice care workers may negatively impact patient care quality (Lupu et al., 2018). It is of the utmost importance that the administrators of hospice care facilities address these issues and provide hospice professionals with adequate support and resources.

The provision of hospice care in the United States is a complex and ever-evolving subject that requires a multifaceted approach in addition to continuous research to improve the QOL for patients as well as their relatives, precisely because hospice care is typically provided to terminally ill patients with limited life expectancy. It was unsurprising that the study revealed that support for the patients' family and caregivers is essential to hospice care management. It shows that family members of hospice care cancer patients also need support for emotional, physical, and, most importantly, financial health needs. Family members often provide the bulk of care for terminally ill patients; therefore, their financial security is vital for personal and patient comfort and longevity of care (Funk et al., 2009). These individuals need assistance to handle the emotional, physical, and financial demands of caring. The administrators of hospice care centers should, therefore, include provision of resources and support for families and those providing care, such as counseling, respite care, and financial aid.

Furthermore, the study finding that administrators of hospice care should address ethical and legal problems, such as making decisions about life-sustaining medications, managing pain and symptoms, and deciding when the patient is expected to pass away, suggested the criticalness of not one, but two major themes: (1) Culture of Care and (2) Training and Training Materials. Participant number I35, for instance, spoke of how the administration transferred the participant from different hospice centers when doctors decided there was nothing else to do after six months of care: Medicare's two terms of 90 days coverage term was exhausted. While this was in part due to a financial security issue on behalf of the patient, the administrative response calls into question the culture of care within the hospice industry, as well as the standards of practice taught during training or provided in training materials.

The experiences of participant I30 were also essential to this study given the ethical and moral issues in hospice administration. The participant was transferred five times before losing their life and was refused a blood transfusion several times in the throes of a terminal condition. Hospice care providers are expected to be well-versed in ethical and legal norms, and ready to guide patients and their families as they make choices based on accurate information; however, studies show that many nurses are not equipped to offer this guidance. Participant I57 gave another insight on these issues 10 days before losing her life: on day 7 her eyesight became gray, the participant started to bleed through her kidneys, and her bladder was retaining blood. The nurse on duty instructed a certified nursing assistant (CNA) to perform continuous bladder irrigation (CBI), a medical procedure that flushes the bladder with a sterile liquid. The CNA made a mistake without the nurse or doctor in the room, inserting the needle far into the bladder, making matters worse for the participant.

Additionally, the study finding that managing hospice care requires consideration of the unique requirements of diverse people, such as military veterans, and to a lesser extent residents of rural regions, led to the theme of Veteran Care. Further, non-white participants with cancer had shortened life expectancy in this study; the researcher interviewed nine non-white participants who needed specialized support and care. The age group among these cancer patients was much younger than their white counterparts at 40–55 years, compared to 55–65 years among the white hospice patients. Hospice care management programs should be prepared to provide care suitable for patients’ physiological and psychological requirements.

The researcher further found that care for veterans with life-limiting cancer diseases may have specific requirements relating to their time in the military. This was another essential finding from the 96 participant interviews. Twenty-six of the total interview participants were veterans, with participant I1 having served in Iraq and attended the Virginia Military Institution. This participant, who died at 48, was also non-white. Hospice care management systems should have the training and emotional support necessary for providers to accommodate all of these demographics. Hospice management programs should address the gaps in access to care and specialized services that may be experienced by veterans, especially in rural locations.

Participant responses indicated that the administration of hospice care in the United States is a complicated subject that calls for a strategy which draws from several disciplines as well as a dedication to meeting the requirements of patients, families, and the hospice care workforce. To guarantee that all people have access to high-quality end-of-life care, constant research, cooperation, and innovation on the part of hospital staff are required. Notably, the quality of hospice care may need to be improved over time to meet these requirements.

The cooperation and coordination of care with other healthcare professionals and community groups is another essential component of hospice care management. Providing hospice care often requires the participation of a multidisciplinary group of medical experts, such as doctors, nurses, social workers, chaplains, and therapists. Thus, to administer hospice care effectively, it is necessary for the members of the care team as well as other healthcare providers in both hospitals and home health agencies to effectively communicate with one another and work together (White, 2016).

In addition, to help with solving this problem, the administrators of hospice care should work with community groups and local resources to meet the social and emotional needs of patients and their families. This may only be accomplished via a collaborative effort, including partnerships with organizations based on religion, support groups, and local volunteerism. Such relationships have the potential to provide patients and their families with extra resources and assistance, and they may also contribute to the development of a community that is supportive of persons who are dealing with end-of-life problems, thereby creating a wider culture of care that extends beyond hospice facilities.

In addition to actively creating a wider culture of care, the administrators of hospice care should also include regular consideration of patient and family financial needs. It is common for families to suffer under the financial strain of caring for a loved one nearing the end of life. Programs that administer hospice care should provide tools and support to families to assist them in understanding the many financial alternatives available to them and how to gain access to financial aid, if necessary. For instance, (a) help in navigating insurance coverage, (b) applying for financial assistance programs, and (c) gaining access to community resources are all examples of this type of support particularly for those lacking financial security.

To summarize the responses from hospice leaders (i.e., doctors, nurses, and leaders), the administration of hospice care in U.S. hospitals is a complicated and multi-faceted topic requiring excellent cooperation, coordination, and resource management to guarantee that all persons have access to high-quality end-of-life care. Hospice care management can give people struggling with end-of-life issues comfort, support, and dignity by attending to patients, family, healthcare professionals, and wider community needs. Hospice care management should consider the effect of end-of-life care on the surrounding environment to best support everyone involved in service provisions and service receipt. For example, as mentioned by the leaders interviewed in this study, it is essential for hospice care management programs to assess the impact of medical equipment and supplies on the environment, as well as implement environmentally friendly practices wherever feasible. Hospice care typically involves the utilization of various medical tools and supplies, so medical equipment should be reusable and amenable to the recycling of materials, and ideally decrease the consumption of energy.

Hospice care management must emphasize the provision of educational opportunities, training and training materials, and emotional support for patients and their families, as well as for staff. Patients and their families need to understand what hospice care entails, including the many services offered and how to access them. Finally, hospice care management programs ought to provide tools and assistance to families for successful navigation through the hospice care system, understanding the potential that available alternatives and accurate information may have on them as they make medical decisions.

In this study leaders discussed providing high-quality care while maintaining patient safety, which was another essential component in hospice care management. Thus, management plans for hospice care should include procedures to (1) monitor and assess the QOC delivered, (2) identify areas in which improvements may be made, and (3) put quality improvement efforts into action. Furthermore, hospice care management programs ought to include standards for infection control, medication management methods, and prevention of patient falls.

The findings in this study regarding administration of high-quality hospice care emphasized attending to patient and family psychology and spirituality. End-of-life care may be a challenging and emotionally taxing experience; hence, patients and their families often need help managing their thoughts, moods, and emotions. Three leaders in the study mentioned chaplain services, bereavement support groups, and counseling services as resource examples that hospice care facilities should make available to meet the spiritual and psycho-emotional needs of everyone involved in the care of hospice patients.

In addition to this, the management of hospice care ought to consider the influence that end-of-life care has on both the resources available in healthcare, and the healthcare system as a whole. It is frequently the case that hospice is more cost-effective than other types of end-of-life care. Hospice care management systems must, therefore, encourage utilization of hospice care as a cost-effective option for different types of end-of-life care. Further, hospice care management programs should promote the integration of hospice care into the broader healthcare system, or at least work toward such promotion. This would include establishing efficient referral procedures, care coordination systems, and payment models.

Discussion of The Research Questions Phase I

The researcher found a relationship between the findings in response to each of the research questions posed. Much is still to be done in the promotion of cancer patient experiences and satisfaction with hospice care. This study contributes affirmations to hospice industry management and attention to positive, relevant relationships linked to aggressive symptom control in support of patients. Importantly, the link between the care demands of various cancer patients and patient satisfaction, and the dependability of data that demonstrate success in internal control are critical management challenges influencing the quality of hospice care provided in U.S. facilities.

According to the study results, some patients receiving hospice care at home were given medication to address the painful feelings they were experiencing. In turn, hospice outpatient care was a better fit for end-of-life patients than inpatient care because there is a greater focus on controlling pain medication, family support, and better financial support. Findings like this can help to close the gaps in leader knowledge of patient care modalities and applied research methods. Additional examples of notable findings in this study with direct connections to practice include:

1. Responses to Question 1, which concerned key management issues in serving cancer patients, indicated that leaders sometimes face confines that they may be unable to manage, and management problems (e.g., staffing, rising healthcare costs, technology, etc.) significantly contribute to the hospice patient experience.
2. Answers to Question 4 centered around the relationship between care needs for different types of cancer patients and patient satisfaction, which was significant. A major theme in the study for patients nearing the end of their lives with cancer was ensuring receipt of care that respects their culture and ethnicity. Another significant finding was the number of veterans interviewed in the study who have, somehow, been forgotten even by staff at the Department of Veteran Affairs (VA) whose job it is to help veterans. The VA offers support to qualified veterans in the final phase of their lives, generally six months or less**.** This multi-disciplinary team strategy, theoretically, enables veterans to live comfortably until they die; yet most veterans participating in this study ended up in private hospice centers or did not meet the qualifying VA terms. In this study, Participant I1 for instance, was a Black patient who served in Iraq, with the majority of the 26 veterans interviewed ending up in non-independent (i.e., nonprofit hospice care) hospice care.
3. Regarding Question 5, on improvement interventions that U.S. hospitals should adopt for the efficient management of cancer patients: replies from five nurses and eight physicians uncovered a need for more acceptable standards and guidelines for

labeling medical equipment. Even though manufacturers know they need to generate or amend instructional and training materials for users of devices previously authorized and sold, the existing FDA premarket review and approval procedures discourage them. Altering the authorized instructions for medical device use necessitates resubmitting the devices for new instructions approved by the FDA via a 510(k) premarket notice review. This requirement is a deterrent to updating producers' instructional or training materials due to difficulty, time-consumption, and cost associated with FDA evaluations. Overall, major changes that improve management capacity and the adoption of efficient training procedures for cancer patients are needed, from national government offices down to industry leaders.

4. Participant survey responses, regarding evidence-based care interventions implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients, revealed an extreme need for more adequate standards and guidelines for labeling medical equipment, specifically for inpatient hospice services. There is presently little information accessible to aid manufacturers in designing devices for specific groups of users. Medical device training techniques and resources are also lacking as existing standards do not consider that healthcare workers and professional users of medical equipment have distinct needs in terms of training and training materials, including instructions for usage.

5. As a final example, responses to Question 7 about the extent to which a relationship linking aggressive symptom management and intense hospice care to provide high-quality hospice care results in low-quality care and management issues does or does not exist, the researcher discovered foundational variables to the research concepts

> concerning outpatient versus inpatient hospice care services and patient responses to medical services. As this study incorporated three prototypes of variables, i.e., independent, intermediary, and dependent, mapped onto Maslow's (1943, as cited in Dohlman et al., 2019) Theory on the hierarchy of human needs motivating behavior, hospice care, leadership management, and patient QOL were found to be determinants of satisfaction for cancer patients (Tripathi, 2018).

These foundational factors showed that outpatient services were the better service approach and pointed the researcher in the direction of addressing managerial failure to provide high-quality hospice care. This was largely due to the patients getting better medical management from the administration by (a) involving second-party vendors for medical devices, (b) contracting nurses for in-home services, and finally, (c) assisting families at home with meeting the food and shelter, safety, security, esteem, and self-actualization of the patient and family as predicted by Maslow (1943, as cited in Dohlman et al., 2019).

Theoretical Framework for Quantitative Phase I

The researcher focused the framework of this study on Maslow's (Dohlman et al., 2019) motivational theory, in the exploration of variables such as hospice care (independent variable), leadership management (intermediary variable), and patient QOL (dependent variable) (Hinojosa, 2019; Yabroff et al., 2019; Ventegodt et al., 2003; Osagiede et al., 2018). The research demonstrated that existing schools of thought focus on participant responses through the lenses of behaviorism and psychoanalysis. Taking a different approach, the researcher discovered keys toward the development of happiness and true well-being in terms of holistic human needs from hospice participant survey ratings and interviews. Each participant in the interview described his or her approach as an existentialistic, self-actualizing process based on personal growth. The researcher thus took each leadership management participants' self-actualization responsibility into consideration for meeting patient needs for quality hospice center care.

High-quality hospice care becomes more accessible, powerful, satisfying, and healthy for both staff and patient participants when Maslow's (1943, as cited in Dohlman et al., 2019) concept of self-actualization can play an essential role in outpatient or inpatient services within hospice centers. As most cancer diseases often do not disappear despite the most promising biomedical treatments, it might be that the real change our patients have for betterment comes through understanding and living the dignified pathway of individual development. The hidden potential for enriching life lies in encouraging patients to recognize that their life passions, needs, and desires to contribute in some form are important to the rest of humanity.

The researcher also found that, with self-actualization, communication between staff members and staff and patients plays an important role, particularly among doctors, nurses, and leaders who are essential to improving life for hospice patients. Furthermore, other important actors include members of the community, family members, and patients diagnosed with a cancer disease.

Family members must be present to provide patients with emotional support and help meet all basic needs before moving on to satisfy other, higher-level needs (Hinojosa, 2019). This study showed linkages between all of the theoretical concepts that framed the research purpose.

Independent Variable

This study links outpatient hospice care services offered to cancer patients, including initial detection, treatment, and motivation, to better focused end-of-life treatment. More critically, and as discussed in the initial sections and literature review on training effectiveness, the findings of this study showed that hospice centers, providing outpatient services, were more apt to equip staff with the skillsets required to handle patients and to adhere to regulations in the healthcare sector (Claxton-Oldfield et al., 2020).

Dependent Variables

Patients' QOL was measured using dependent variables for inpatient service. The responses showed a need for more quality care by staff and leadership. For example, topics discussed in the prior section that surfaced within the study centered on the awareness of policy and need to survey patient complaints. For example, the CNA who made a mistake in inserting a needle into a cancer patient in the absence of the primary nurse, is an instance of the need to ensure that staff are following center policies or industry standards. Awareness creation is instrumental in enabling the staff of hospice centers to accomplish the set goals of optimal patient outcomes and supports that nurture a culture of responsiveness, as well as in forming the basis for better service delivery for all (Hakola, 2019).

Similarly, insight into policy compliance levels also serves to guide management toward the ideal strategies to adopt to achieve desired patient outcomes (Kneuss et al.,2019). These ideal strategies can assist in the formation of leadership management theories in alignment with the transformational leadership theory. Leadership management theories lead the school of thought in hospice care and would have helped correct or even prevent the incident in the above scenario. This would have in turn helped the patient receive better hospice care services: just because a facility is labeled hospice or end-of-life care they should not neglect patients’ quality of life (Leadership Theories, 2021). This notion may especially apply to hospice care center treatment within the health system. Why comfort patients just at the end of life? Can we cure, treat, or otherwise save them? Among other problems, the primary care management subsystem for leadership and aspects of leader operations may require a different thought process to solve hospice service problems. Again, participant I35, who was transferred numerous times to different locations with her kidney, eyes, and bladder failing at the end of her days is an example of a fragmented care system. Each center refused to administer treatment for a blood transfusion, and the problem brought to light unstable facility leadership across the centers: one center did agree to give the patient a transfusion, giving the family another week to see their loved one live. According to several participants, leadership in hospice inpatient services appeared to act like God in the decision-making process, which is too often ingrained with leader or facility priorities over patient needs (Dixit & Sambasivan, 2020). Leadership largely controls resources, isomorphism, accommodations for changing circumstances, and fundamental elements of resource dependence as pointed out in leadership theory (Meier, 2010).

Intermediary Variable

The researcher further tracked the management technique and leadership within the hospice patient experiences using Maslow's (Dohlman et al., 2019) motivational theory. Namely, this study addressed the importance of meeting higher quality control standards and pivotal patient needs, such as physiological safety to reduce anxiety while treating symptoms and suppressing pain by identifying favorable results, which included outpatient services. Family members received better management services from the outpatient service providers, and they were also able to be more present to provide patients with basic human needs, including emotional support (Hinojosa, 2019).

Themes Discovered Phase II

Themes were discovered from the qualitative responses gathered using phone, email, Zoom, and face-to-face interviews. The audio was recorded utilizing the dictation element in

Zoom. The dictation was then manually reviewed and saved, giving the study a transcribing accuracy of 100%. Purposeful sampling and pre-determined interview questions were used for this portion of the study. The participants included hospice patients, nurses, doctors, and managers/leaders. The researcher employed the open-ended question method and offered each participant an opportunity to expound on the QOC experienced among patients, or their leadership style to enhance job satisfaction and decrease patient dissatisfaction among staff.

Participants were labeled with the letter "I" for the interview and a number (e.g., I1) to maintain their confidentiality. The software NVivo was utilized to code the information collected. Creswell et al. (2003) posited that NVivo is a practical software that provides researchers with enriched qualitative data analyses that may help them give clear and significant material to administrators and other stakeholders to support determinations. In addition to NVivo, the researcher utilized Microsoft Excel to unwrap the coatings of each code. Themes, words, phrases, or data segments were continually discovered to correlate with participants' answers until all were analyzed (Creswell & Poth, 2018).

The leadership problem in question was management issues that contribute to patient outcomes within hospices in the United States and further results in QCI and customer dissatisfaction (Jacobs & Shulman, 2017; Osagiede et al., 2018; Pesut et al., 2020). Thus, themes were generated in response to the following: (1) failure in how management issues impact overall patient outcomes and/or job dissatisfaction and corresponding worker conduct (i.e., turnover, burnout, and performance), (2) how leadership failure affects quality control factors, and (3) customer dissatisfaction with management leadership, leadership styles, and standards. The results of this study corroborated prior research studies. The themes discovered in this study may serve as educational and emotional support opportunities for training or training materials, financial requirements, home medical equipment, and software (e.g., medical devices and health information technology, etc.), caregivers and those receiving care, particularly patients in residential healthcare settings and those who are veterans (see Figure 1**).**

Interpretation of The Themes

Culture of Care

Participant I29, a nurse, commented on management leadership sustaining a problematic culture amongst patients when the center's standards measures are not placed in staff training. In this participant’s experience, the opposite was true: the center had built a culture emphasizing professionalism and objectives from leader to employees, i.e., top-to-bottom, through hands-on experiences. Thus, this participant’s job as a managing nurse was to cultivate a relationship with employees. If there were issues, open communication was another standard implemented. The process described by I29 meets industry standards, showing that the most effective leadership methods lie in training and on-the-job communication. These steps show appreciation for the team for the handling of patients. This process also exemplifies models of anticipation that demand daily process reports. Semachew et al. (2017) validated I29's assertion that communication, the cultivation of patient relationships, and the careful assigning of patients are all key to job satisfaction, followers understanding each other, and job commitment.

Training or Training Materials

Participant interviews for I3, I5, I7, I10, I46, I65, I66, I69, and I70 were provided by a combination of nurses, doctors, and leadership. Their responses helped identify some of the issues involved in managerial failure to provide high-quality hospice care in healthcare facilities, which often results in quality control problems and customer dissatisfaction (Jacobs & Shulman, 2017; Osagiede et al., 2018). High-quality hospice care was identified as a factor in keeping patients encouraged and engaged. The participants showed that management leadership is critical to improving hospice care satisfaction for patients. These participants' responses further reflected Rezaei (2016) and Owusu's (2014) investigations of staff and patient satisfaction. These studies offered opportunities for administrators to understand their staff and patient feedback, as well as capitalize on the reported levels of satisfaction from both groups.

Participants I46, I68, and I69 were all hospice medical doctors (i.e., MD). They spoke about the need for a comprehensive management training program that delivers hospice-specific information and enables managers to incorporate issues they face in the industry. Participants I25 and I65 specifically homed in on the training material at their facilities, describing how it provides learning skills that leadership requires to fulfill the challenges and work with the changes they face daily. Training programs, according to the participants in this study, help improve leaders, particularly when they communicate effectively and understand lower-level employees' work conditions.

Emotional Support

Patient participants also contributed valuable insights in the process of theme discovery in this study. For instance, for (1) I1, (2) I27, (3) I37, (4) I44, (5) I57, and (6) I67, leadership is something that they identified with and embraced. The researcher identified process features from the researcher's own experiences that, when in place, can enable caregiver involvement, and each of these patient participants endorsed them as accurate. Notably, this group of participants' voices represents an older population with a strong caregiver presence, both as inpatients and outpatients. In both settings, emotional support from family members being around and able to spend time and give informal caregiver support represented 85% of the Emotional Support theme. Unsurprisingly, over half of the patients in this study lived with their caregivers.

Participant I37 credited this setting as the best secure care extension for the end-of-life hospice care. Many hospice centers in the United States are overwhelmed with patients, and in some cases, with few nurses to several dozen patients (Haugland & Reime, 2020). Participant I37 further relied on the problems of (a) failing leadership, (b) an empty room and nurses having gone AWOL, and (c) dependence on technology for answers in their responses to study questions.

Veteran Care

The Veterans Health Administration uses a management leadership style to improve employee job satisfaction (Pullen et al., 2023). As a leader in hospice centers, the researcher interviewed participant I32 regarding modeling standards for the rest of the staff to simulate. Sy (2010) asserted that developing the standard for followers improved the followers' level of job satisfaction; thus, workers treated negatively by their superiors tend to be dissatisfied with their employment. Each worker has a distinct demand and equipping them with the essential support and tools required helps develop a culture of job fulfillment. The researcher's interview with participant I47 resulted in a response on management leadership in association with other leadership classes; this aligned with Maslow's (Dohlman et al., 2019) Theory of Motivation that by allowing individuals to express their problems employee morale and satisfaction can be boosted significantly.

Participant I47 additionally clarified that collaboratively seeking out workers' views, particularly concerning patients' QOC is important. The participant further described business transformations in daily shifts, and how such occurrences might ensure achievement of a daily goal, as well as motivation concepts and worker buy-in of facility standards or processes. According to these participants, workers' emotions and motivations are crucial for effective hospice care. Workers must be able to voice their emotions and motivations without concern of repercussions. Participant I47 ended their interview by discussing the Veteran Center and the need for our veterans to have the best services and the highest QOC.

Motivation Management Leadership Style

In many hospice centers, training methods include concepts of beliefs and empathizing with staff nurses and patients (Davis et al., 2023). Management leaders empower workers through education, continued training, mentoring, and influencing, thus Ziwei et al. (2020) believe that motivational practices combined with managerial skills are stimulating, inspiring, and best for motivating employees. Motivation Management Leadership Style was identified in responses from interview participants I7; I10; I23; I25; I29; and I68. According to Duchscher and Corneau (2023), professional growth possibilities assist leaders in identifying their flaws and making them more effective and confident when faced with different situations. Such development can help leaders adapt to the environment at various points in time, strengthening their ability to change.

Financial Security

Financial requirements was another theme uncovered from this research. Namely, participants referenced red tape, policies, and procedures as frequent mediating financial factors in hospice care (Davlyatov et al., 2023). Financial challenges often accompany severe illness as patients enter the hospice system; thus, participant number I35 showed the importance of knowing about the available resources in a facility so that patients can organize and take on any challenges, including medical debt. Patients are often transferred several times before meeting death. According to Davlyatov et al. (2023), healthcare finance is a leading problem in Medicare cancer expenditures, especially in the last month of life, sometimes leading to aggressive cancer care at the end of life (ACEOL), which is likely to be of poor-quality if they do not have financial security.

Communication

Communication also plays a role in the daily running of a hospice center, including how standards are implemented and how the facility is operated. Participant I4, for instance, talked about the biggest problem being that procedures periodically do not allow for thinking outside the box. Participant I34, who has been in the industry for 20 years, agreed by sharing that there is sometimes a lack of direction and communication which leads to failure on the part of leadership management. The lack of communication to provide direction is the most significant challenge in hospice facilities according to these participants. Furthermore, participant I34 expressed their experience that about 45% percent of the communication problems in hospice centers come from the administrative position, and 35% stems from clinical staff. Kogan et al. (2023), discussed the 80/20 ratio rule within the communication aspect in hospice care. The author succeeded in showing that hospice care is an inter-professional specialty that provides effective symptom management when decision-making needs are facilitated by communication throughout cancer patients' end-of-life stage. Mysore and Ranjit (2023) demonstrated the advantages of timely integration of hospice care with routine care, such as improvements in physical and psychosocial symptoms, QOL, satisfaction, and care costs.

Staff Burnout

Emotional support, as demonstrated by the Emotional Support theme in this study, was endorsed as vital by all 96 participants: not only for patients, but for staff in the prevention of burnout. For example, emotional support plays an important role in trust-building between leader and patient. Through this study, the researcher discovered that burnout is one of many terms used often amongst staff, leadership, and patients within hospice centers. This was evidenced by all of the patients and leaders interviewed who referenced burnout. Family caregivers for cancer patients experience high stress and burden, as well as reduced QOL, thus, interventions to enhance the coping skills of caregivers may also be helpful to patients and hospice leaders. Research shows that coping skills training interventions improved family caregivers' QOL, sense of burden, and skill proficiency more than emotional support alone during hospice care (Newman & Schwarz, 2018).

In Section 1 of the literature review, the researcher posited that leadership theory concepts such as mentoring, motivating, and clear and direct communication approaches are important to hospice care. The participants’ responses in this study further support the notion that leadership is a vital component of operating a thriving institution. For instance, Motivation Management Leadership Style is one that allows leaders to form and identify the demand for change while building employee's self-esteem (Dohlman et al., 2019). The researcher concludes that there is a definitive answer as to how to lead management in the hospice industry for cancer patients: Leadership which is motivating and that listens to employees makes workers feel valued and connected to the organization and mission (Newman & Schwarz, 2018).

Representation and Visualization of the Data

The data visualization delivers an account of how the participants from a total of 96 participants were interviewed; the researcher drew several themes to address management's failure to provide high-quality cancer care in hospice healthcare facilities in the United States, resulting in quality control issues and customer dissatisfaction among cancer patients (Marzal-Alfaro et al., 2020. The representation and visualization of the data are drawn from the overwhelming theme of the research, emphasizing many participants' views and themes that were generated in response to the following: (1) failure in how management issues impact overall patient outcomes and job dissatisfaction and corresponding worker conduct (i.e., turnover, burnout, and performance), (2) how leadership failure affects quality control factors, and (3) customer dissatisfaction with management leadership, leadership styles, and standards. The results of this study corroborated prior research studies. The themes discovered in this study may serve as educational and emotional support opportunities for training or development of training materials, addressing financial requirements, incorporation of home medical equipment and software (e.g., medical devices and health information technology, etc.), caregivers and those receiving care, and particularly patients in residential healthcare settings and veterans. A graphical presentation of the participant's responses is shown in Figures 3 and 20.

Figures 3 through 18 show a visualization of the data entered into the software. The statistics show a correlogram of the participant interview by number, and an assigned unique code for each participant. Those factors are statistically calculated to examine the frequency of code application across participants and to estimate the qualitative effectiveness variable. This data is then used to assess variation between health plan correlation with variables such as age and the independent or dependent variables.

Figure 3

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group

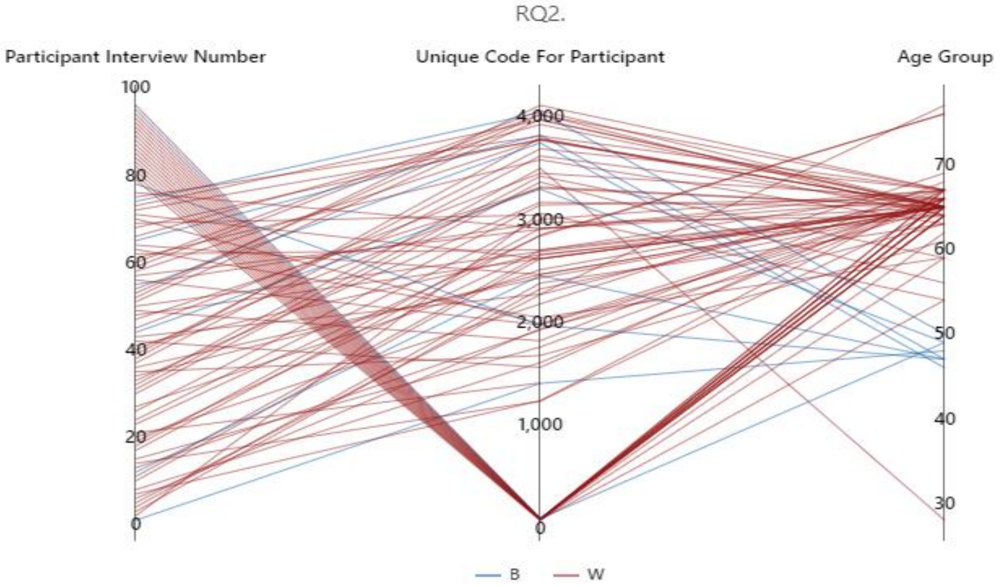


Figure 4

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group ***RQ2.*** *= Management Leadership*

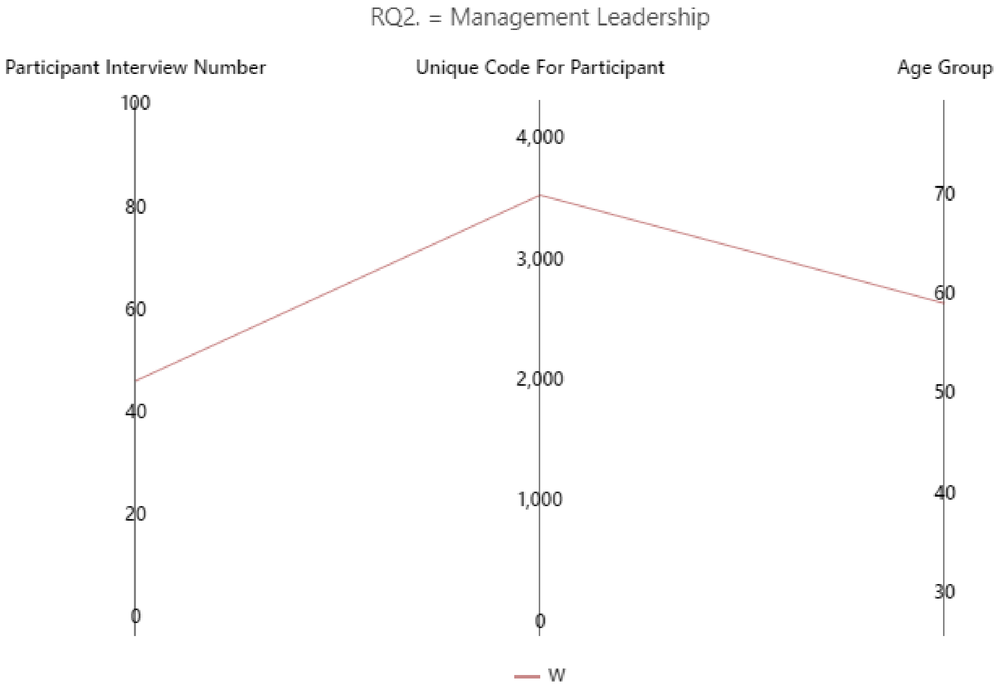


Figure 5

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group

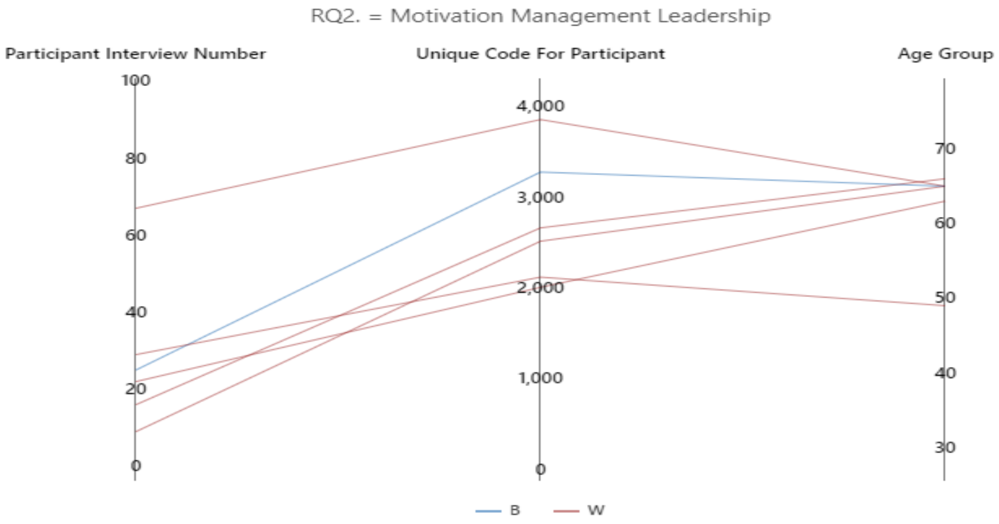


Figure 6

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, ***RQ2****=Training, Communication*

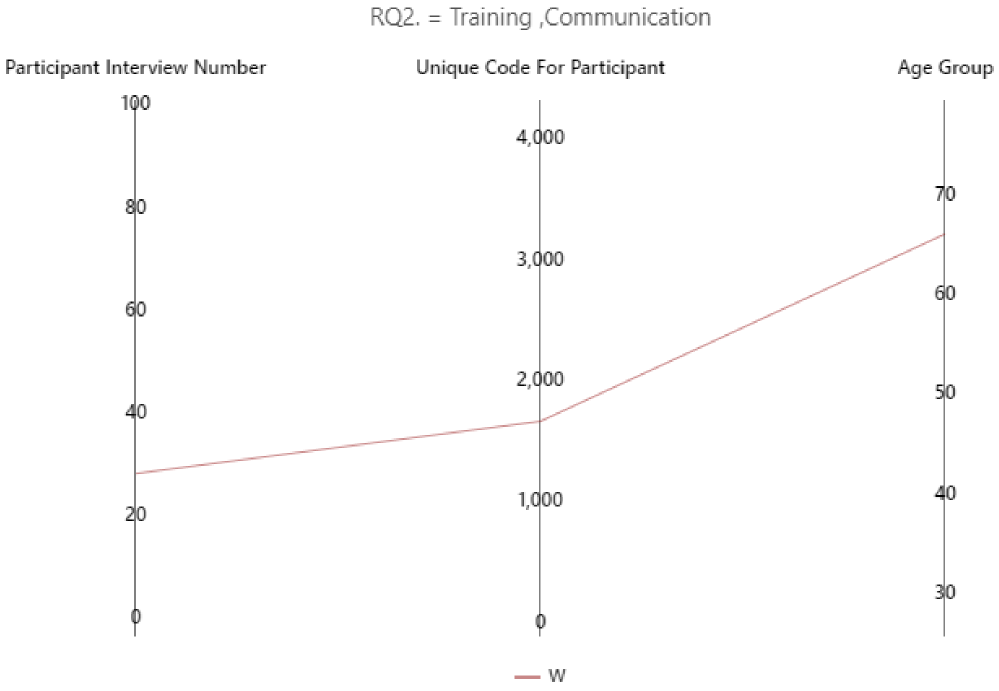


Figure 7

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, Veteran Healthcare Provider

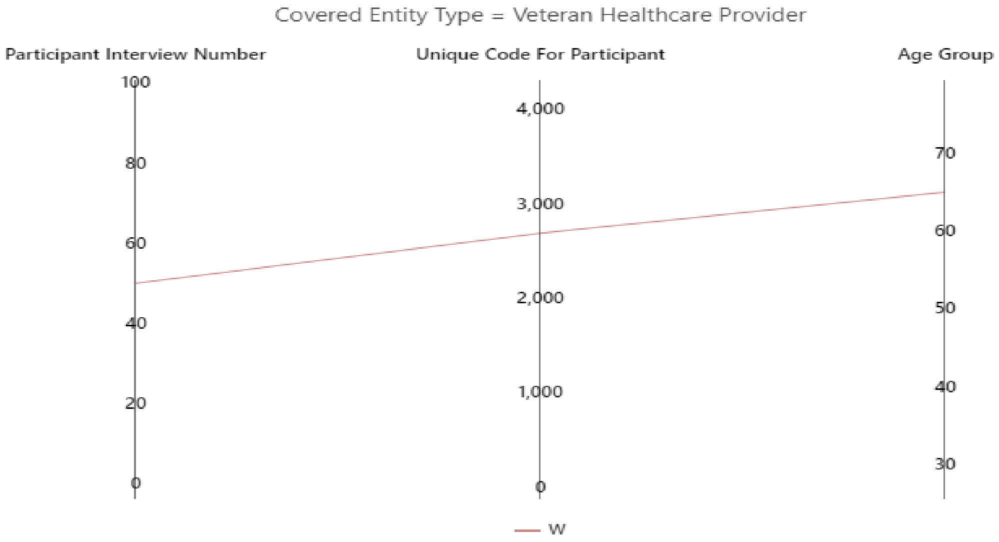


Figure 8

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, RQ2=Business Associate

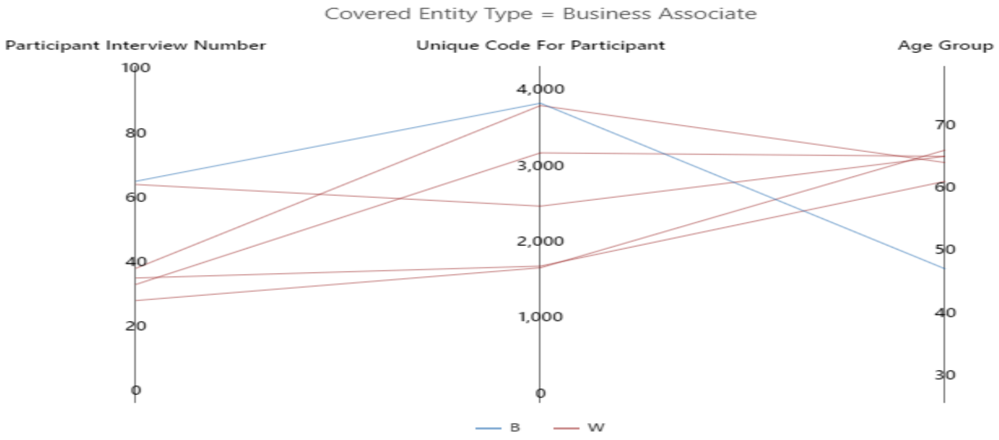


Figure 9

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, Business Associate (Doctor)

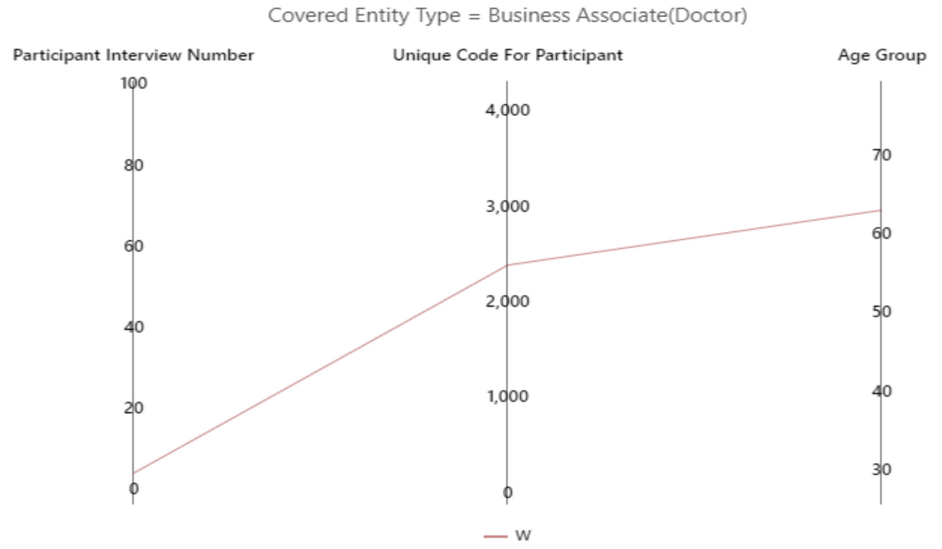


Figure 10

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, Business Associate (Nurse)

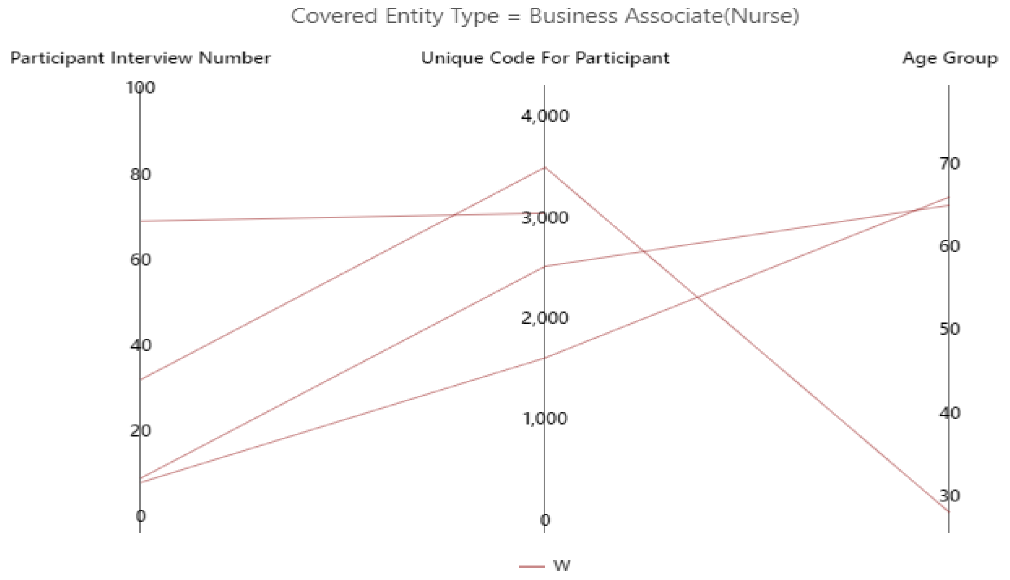


Figure 11

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, Health Plan

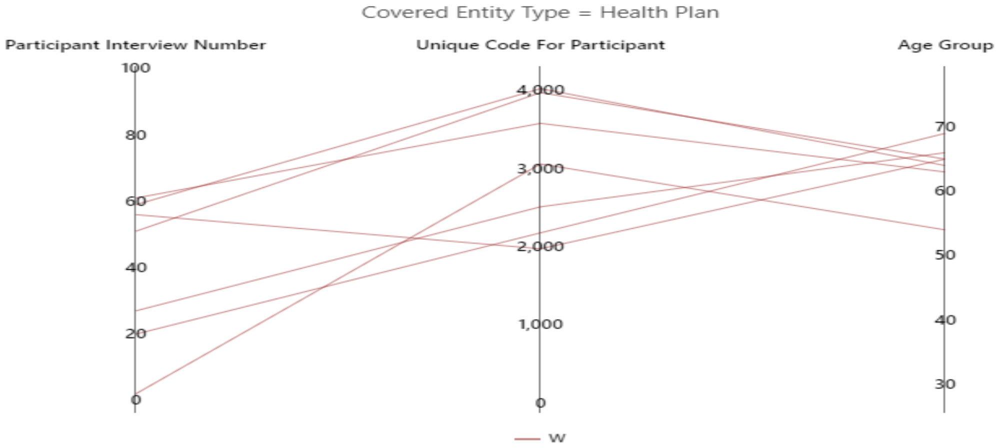


Figure 12

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, Healthcare Provider

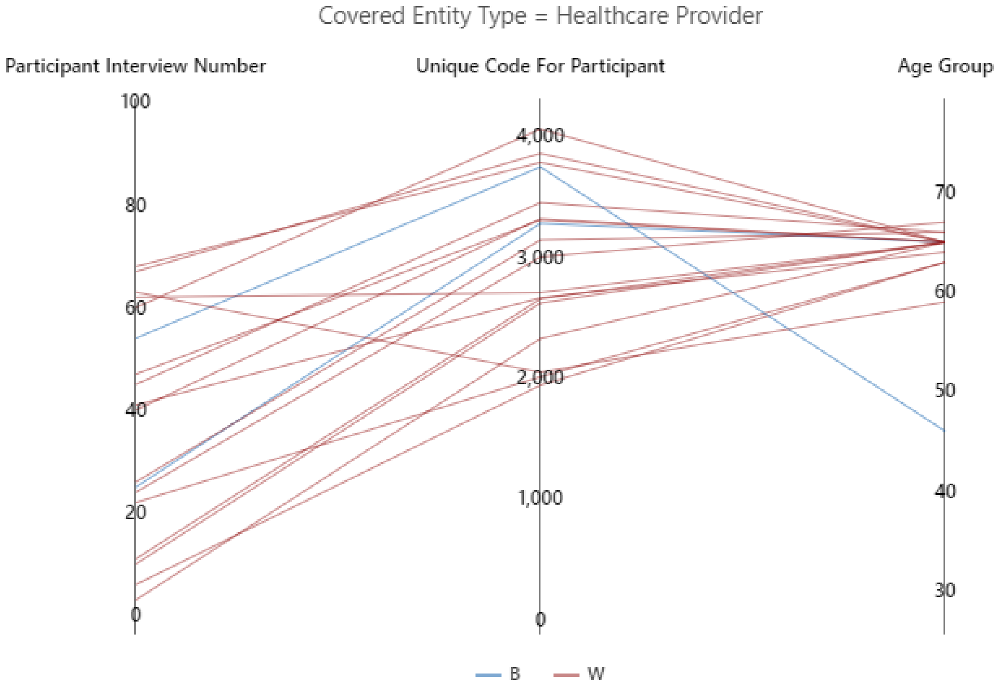


Figure 13

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, Medicare

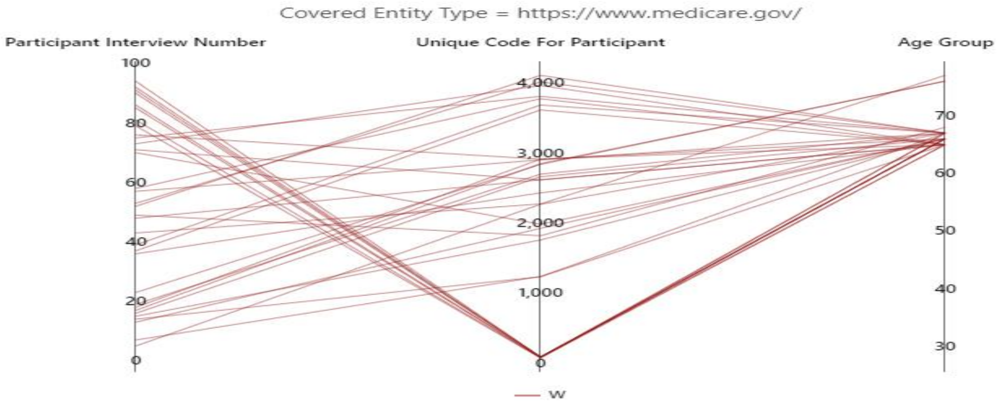


Figure 14

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, Medicare, and Health Provider

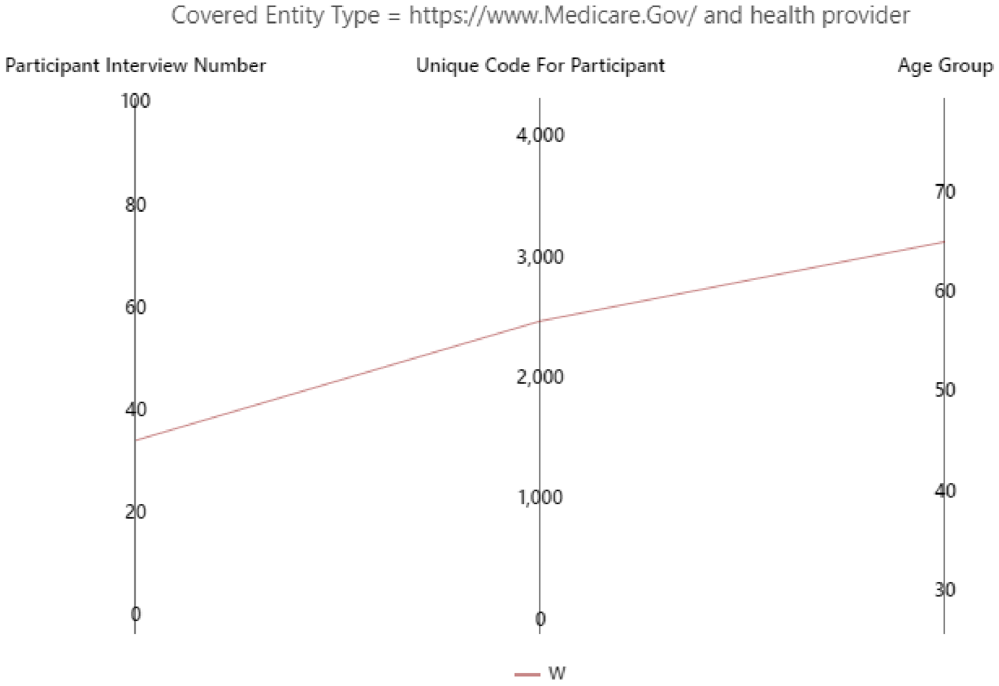


Figure 15

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, Veteran

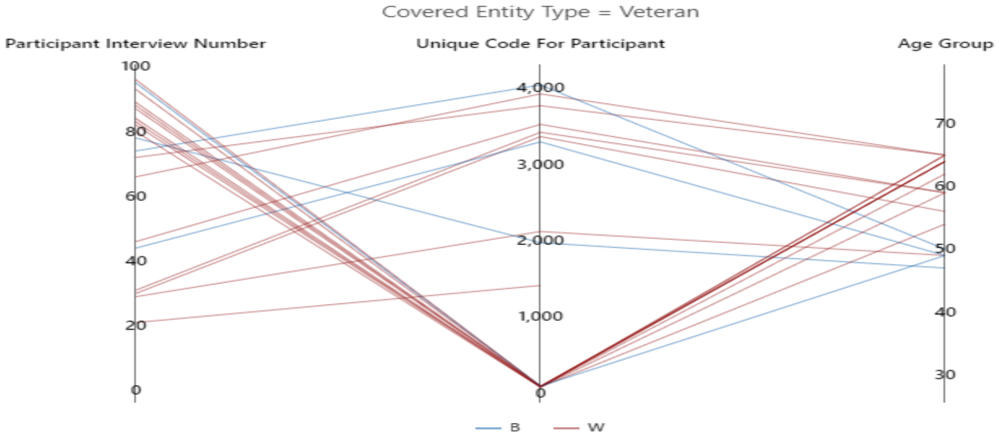


Figure 16

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, Veteran Health Plan

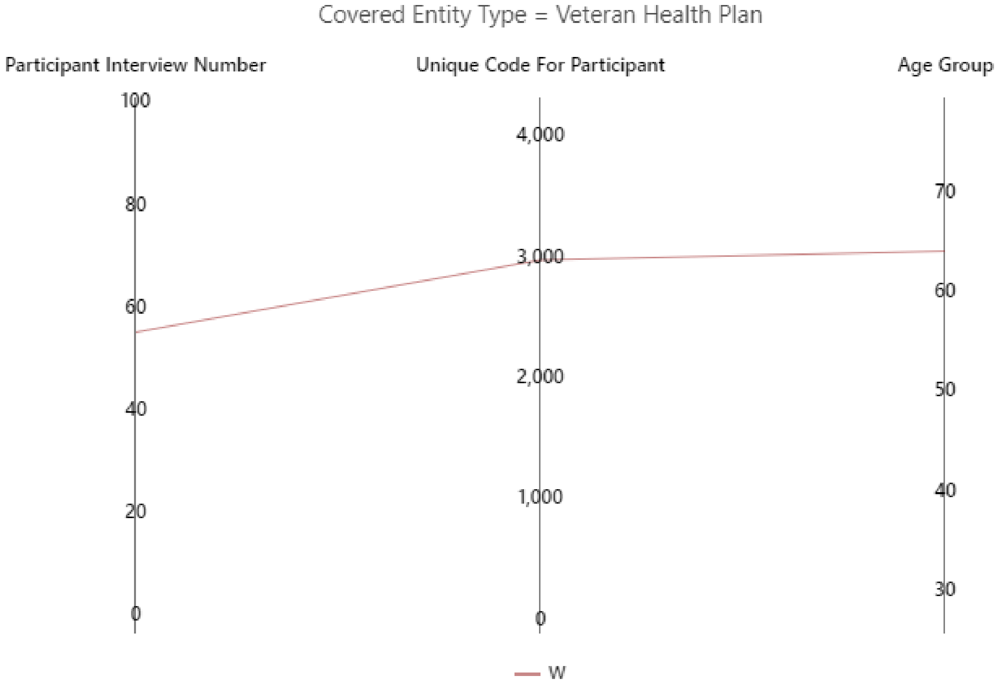


Figure 17

Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group, Veteran Healthcare Provider

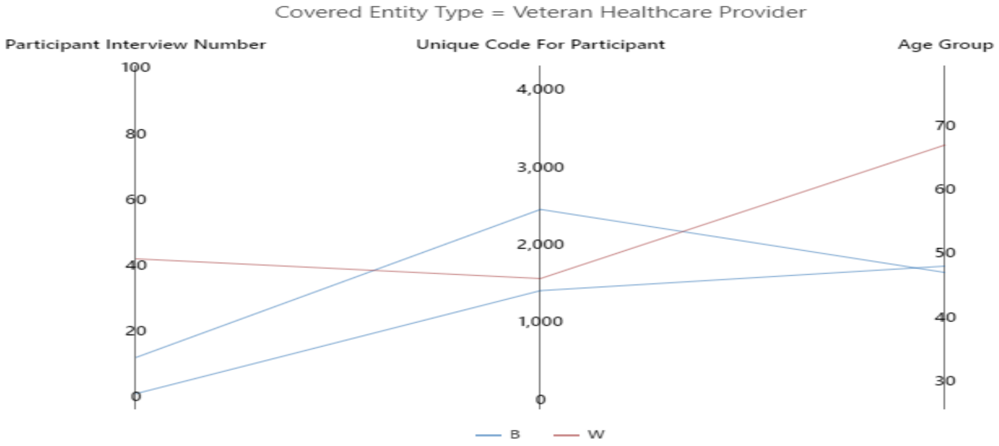


Figure 18

*Parallel Coordinates Plot of Participant Interview Number, Unique Code for Participant, Age Group****, RQ3***

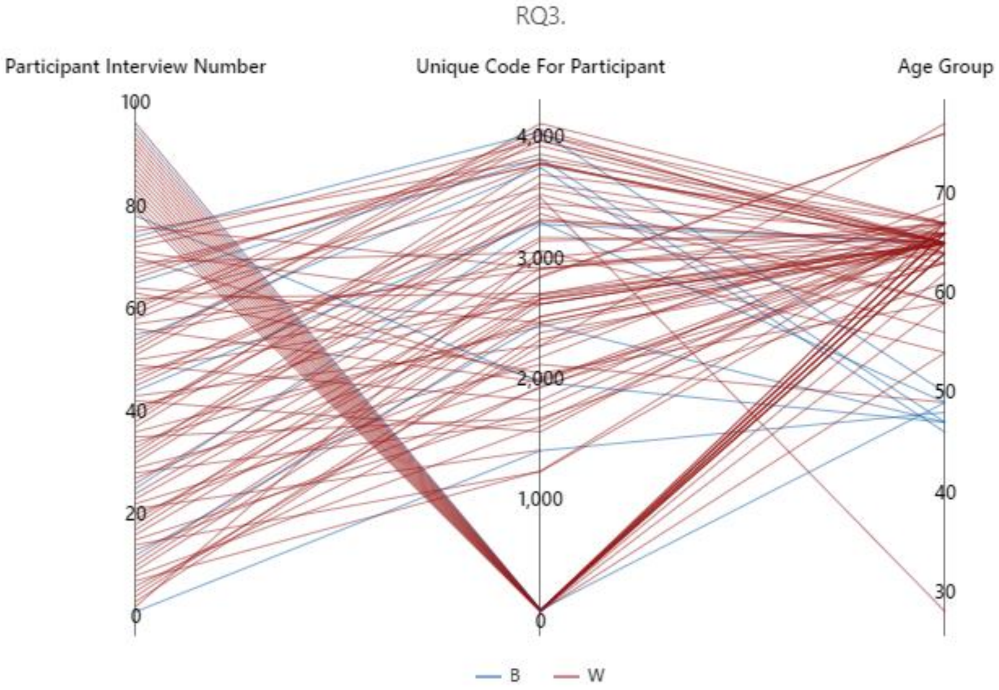


Figure 19 shows a visualization of the discussion age group of the 96 participants interviewed; the researcher drew several themes in addressing Question 3: How does assessing patient needs in cancer care contribute to quality control issues and patient satisfaction? Concerning Question 3, which discussed how assessing patient needs in cancer care contributes to QCI and patient happiness, responses revealed a significant need for higher patient knowledge of medical technology use, in turn, is a necessity for test devices for features essential for good practice for management leadership in hospice centers.

Figure 19

Themes In Age Group

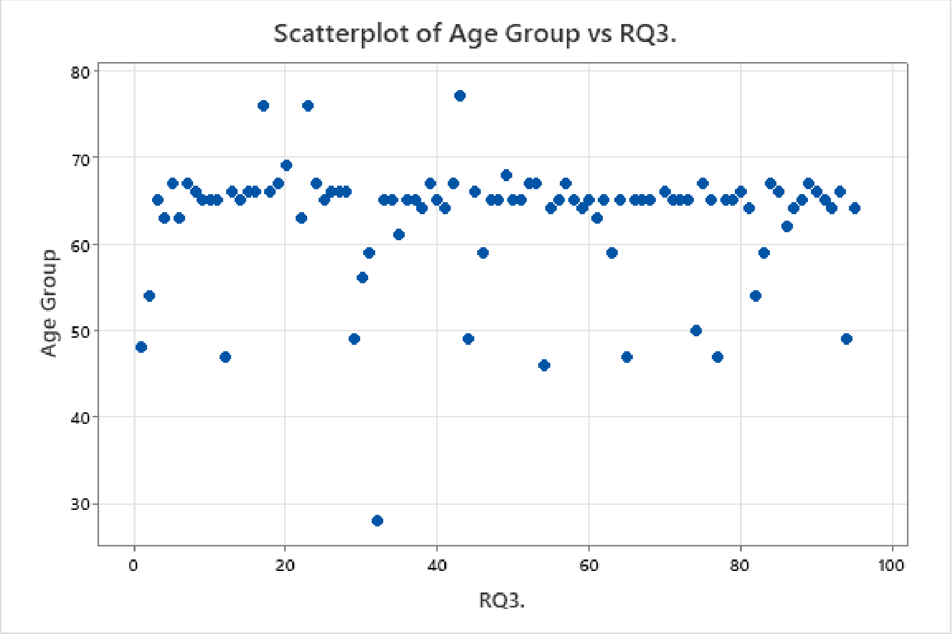
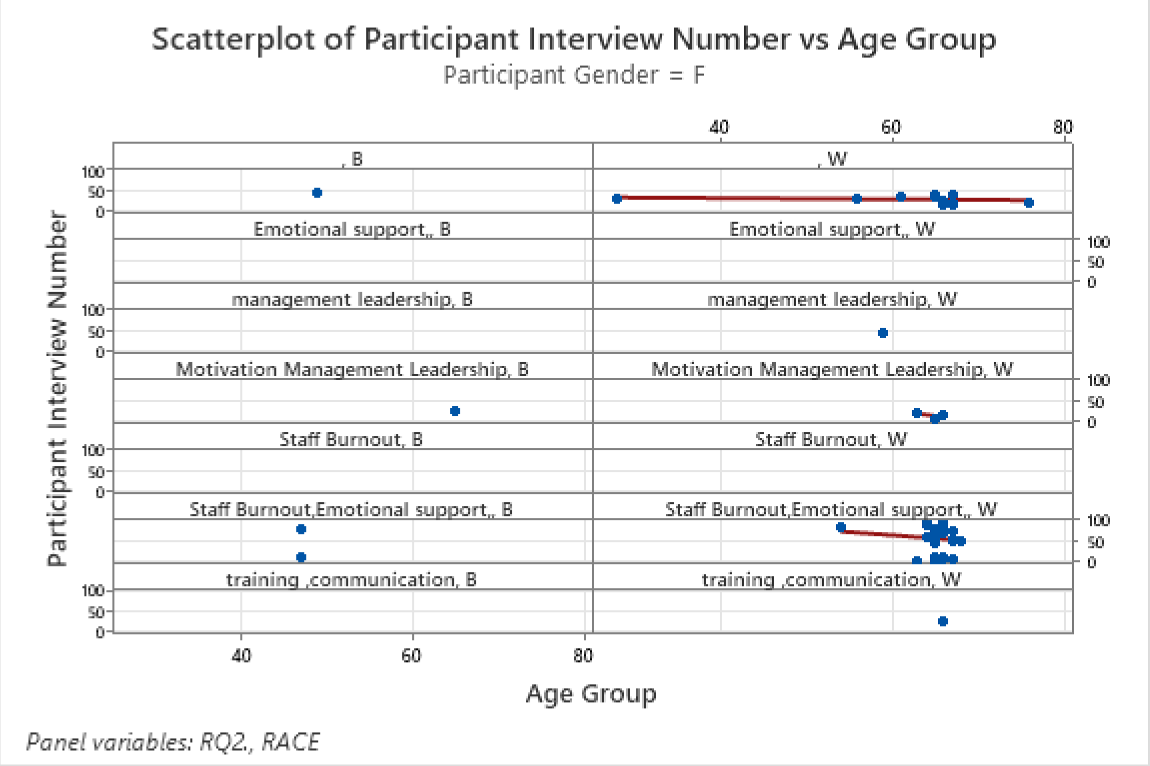


Figure 20 shows scatter plot representation and visualization of the data drawn from the female participants, the overwhelming theme of the research, emphasizing emotional support and what is needed for failure in how management issues impact overall patient outcomes and job dissatisfaction. Emphasizing the psychological perspective and analyzing the female discussions in this study gave several findings for emotional support. Several female accounts are represented by nurses and participants who were transferred from different hospices before their end of life.

Figure 20

Emotional Support and Management Leadership



Relationship of The Findings Phase II Qualitative

As part of this study, the researcher investigated the circumstances surrounding the inability of hospice care management to provide adequate hospice care in healthcare facilities. According to Bormann and Rowold (2018), leaders are obligated to acknowledge the significance of discomfort experienced by patients and nurses. Unfortunately, the results of this research study corroborate the existence of a knowledge gap in the area of leader empathy, and thus focused on examining the elements that influence the decision-making process, including experience with and comprehension of the relevant patient, family, and facility conditions and policymaking. Throughout review of the literature, the researcher found that most communication dealt with the same central problems or notions. Thus, the researcher used a questionnaire with open-ended qualitative questions to collect data from hospice industry professionals and patients to determine the relational importance between the following health care components:

- Key management issues affecting the quality of hospice care
- Healthcare needs for different types of cancer patients and patient satisfaction
- Hospice care improvement interventions
- Aggressive symptom management

The researcher identified the importance of the relationships between these characteristics of hospice care by analyzing the quality of the data obtained from the qualitative interview responses questionnaire data via the NVivo software programs, respectively. White (2016) asserted that typical statistical examinations include parametric tests. Indeed, in many studies on hospice management, parametric tests were utilized more frequently than nonparametric tests. Thus, most hospice management researchers are familiar with parametric tests, and statistical software packages strongly reinforce parametric tests (Clark, 2019). To conduct parametric tests, it is necessary to make a fundamental assumption known as normality, which states that the distribution of the sample means should match the trend found within the larger population. When this assumption is met, the parametric test is trusted to produce accurate results because it relies on assumptions.

However, tests that do not rely on the assumption of normalcy, known as nonparametric tests, are alternative procedures that may be utilized in research. Namely, statistical approaches that are utilized to study variables dependent on signs and ranks are known as nonparametric tests (Creswell & Poth, 2018). The researcher calculated descriptive statistics to analyze and characterize the quantitative data from the field study. Specifically, the researcher experimented to determine the optimal sample size for this study and found that the medical record of the Research Institution organization yielded a sample size of 1,300 viable candidates. The population of hospice care facilities across the United States was assumed to be normally distributed, thus a random sample of 96 people was drawn from the pool of 1,300. Preliminary and statistical examinations of the quantitative data included a reliability test based on White's (2016) alpha recommendation, an ANOVA, primarily one-way, and a T-test.

While most of the quantitative procedures and results from this study were previously described and reported, respectively, the following ANOVA results are reported here in an effort to synthesize the MMR findings as shown in Table 7.

Table 7

ANOVA Results

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	1.172[a]	1	1.172	3.061	.083[b]
Residual	35.984	94	.383		
Total	37.156	95			

a. Dependent Variable: the key management issues affecting the quality of hospice care for cancer patients.

b. Predictors: (Constant), the assessment of patient need in cancer care contributes to QCI and patient satisfaction.

Discussion of The Research Questions Phase II Qualitative

This sample was used for both designs, size was determined using a confidence level of 95% based on a population of 1,300 people, and an acceptable margin of error of 5% was allowed. The qualitative portion of this study was essential considering the variety of questions researched, as well as when and what information would be most helpful to patients, leaders, and other stakeholders (Creswell & Plano Clark, 2007; Tashakkori & Creswell, 2007). Two questions, presented below, posited that management issues such as staffing and rising healthcare costs significantly contribute to hospice patient experiences for cancer care services in the United States (Marzal-Alfaro et al., 2020; Tandon et al., 2020).

Responses to Question 1 identified management issues that affect the quality of hospice care for cancer patients and provided an evidence-based framework for assessing hospice patient experiences and general patient outcomes. Within the research finding, the researcher discovered major themes, such as burnout, equipment malfunction, and staff shortages as needs and problems. The objective was to incorporate both qualitative and quantitative data into a narrow scope of research examining specific management issues affecting the hospice experience for cancer patients. Research by Carmont et al. (2018) also identified characteristics that revealed management issues affecting patient care and hospice experiences as a focus in need. The qualitative research questions in this study helped the participants express the patients' view and close gaps in knowledge about hospice care; many participants contributed vital information on QCI and patient satisfaction through their discussions about lack of medical device information and financial difficulty during and after the death of a loved one. Further:

1. In response to Question 2, on how each management issue contributes to patient outcomes, the researcher discovered that patient-centered cancer care services require a steadfast emphasis on patients' physical and emotional well-being to improve their QOL and prolong their lifespan. In turn, many inpatient hospice centers need help meeting demands through advancement interventions, such as decreasing the nurse-

to-patient ratio to help lower hospice death rates. The researcher further found lower staff shortages for outpatient home service compared to inpatient, where services are contracted out. Hospice care for cancer patients entails specialized treatment therapies, immensely contributing to increased care costs.

2. Concerning Question 3, which discussed how the assessment of patient needs in cancer care contributes to QCI and patient satisfaction, responses revealed significant need for higher patient knowledge of medical technology use. Patients’ needs for assessment in cancer care continues to evolve. Facilities and professional users should test devices for features essential for good practice as well as research device effects on the quality of supportive care. All 96 participants interviewed expressed a need for more knowledge of the hospice process and technology usage.

Another overwhelming theme was that diversity among hospice patients continues to represent one of the most significant barriers for access to quality care. Care providers in this study discussed homing in on equity and inclusion in how insurance is covered, as they have witnessed some losing coverage and others not having one, having higher co-pays when they are covered, or not being fully covered. Participant I35 comes to mind on the subject of coverage: She was a Black female of 65 years of age who had business insurance as a business owner and Medicaid. After six months of care her insurance expired, including her 90-day term. She tried using her business insurance or paying cash for a blood transfusion to stay alive. Still, the doctor did not answer, and I35 received permission for a transfusion only after being transferred to three different hospice centers, two of which were major hospitals.

The Conceptual Framework Phase II Qualitative

The researcher employed motivation and leadership theories to assess participant experiences and/or management styles between different hospice centers in the United States. These two variables were used to draw answers from participants about access to independent (i.e., for-profit) and dependent (i.e., nonprofit) hospice centers. In analyzing the relationships between the categorical variables of interest and actors and theory under study, leadership management style significantly determined hospice care design and style (Ventegodt et al., 2003). The main concept studied was the relationship between leadership management and Maslow's (Dohlman et al., 2019) hierarchy of needs theory.

Intermediary Leadership Management

The researcher provided hospice leadership nurses, doctors, and leadership with a wide range of questions about change management. Their answers in turn provided benchmarks for prioritizing the need to encourage and motivate staff and patients alike. Most noteworthy, the management representative in all leadership interviews focused on enhancing optimal quality services.

The researcher later employed the results of this category to check participant responses to other research questions and found remarkable consistency. The responses from leadership management focused on patient welfare, and the care facilities' management model, which should—according to this category of participants—be geared toward enhancing hospice care in the interests of patients' concerns (Giammalva et al., 2018). All the participant interviews within the administration further mentioned occupation stress, such as burnout, anxiety, and turnover. Their goals were in alignment with Maslow's (1943, as cited in Dohlman et al., 2019) hierarchy of needs. Notably, the respondents' model of care underscores the value of Maslow's theory:

physiological needs, safety needs, love, belonging needs, esteem needs, and self-actualization needs are all critical to hospice patient satisfaction and welfare.

According to this notion, the patients' need for quality care is crucial in supporting individual psychological state (Noltemeyer et al., 2021). Patient satisfaction affects many patients' mental and physical health (ASCO, 2016). The findings from this study significantly showed many patients are unsatisfied with their care in inpatient hospice centers compared to outpatient, where the services are like ordering a buffet. At the end of their lives, outpatient cancer care recipients are met with compassion by family members at home (ASCO, 2016).

Anticipated Themes Phase II

The researcher matched anticipated themes related to the initial expected focus by utilizing data collection implementation techniques and deductive and inductive journaling to mitigate bias in the gathered data (Terrell, 2012). The researcher assigned codes to each theme and participant; this approach helped provide an automatic convergent parallel to collected data. The researcher transcribed the interview notes into the research software; the coding gave similarities and trends for the basis of findings and recommendations. The themes found within the research concept and literature review came front and center in the conclusions.

Several challenges hinder leadership management's ability to provide high-quality care to hospice patients consistently. Teams are large, team membership constantly changes, and physicians are often spread across multiple units and floors. Moreover, patients and family members usually are inadequately informed and lack opportunities to partner in decision-making. The themes discovered, such as communication, training, emotional support, and financial support, lead directly to the study's concept. These findings represent complementary and mutually reinforcing elements of redesigned hospice care management. The researcher's objective was to identify factors and strategies associated with successful implementation and evaluate the impact on patient quality care and leadership management to improve. These study findings may help close the gaps by providing that information.

Relation to Literature

The focus of the literature review in this study was inefficient management of hospice care services by hospital leaders, resulting in QCI, customer dissatisfaction, and detrimental staff dynamics such as burnout and compassion fatigue (Abu-Odah et al., 2020). The review provided a comprehensive understanding of the problem factors in hospice patient satisfaction and the fulfillment of cancer patients' wishes at the end of their lives (Johnston et al., 2020; Meier et al., 2017; Nagata et al., 2021). From the literature review the researcher concluded that correlations between the study variables may indeed exist in contemporary hospice care and should be examined as an MMR study. The conceptual diagram in Figure 1 thus consolidates Maslow's (Dohlman et al., 2019) theory and leadership management theory. The researcher further focused on understanding the quality of hospice care and determining whether it can be improved based on patient experiences with management in the U.S. hospice care industry.

The terminology linked to the body of literature on hospice care leadership and patient satisfaction included keywords such as:

- Autonomy
- Maslow's Theory
- Leadership Management Theory
- Quality of Life (QOL)
- Comfort Care
- Medicare and Medicaid

- Burnout and compassion fatigue
- Quality of Care/QOC
- Quality Control Issues/QCI
- Hospice Care
- Lifelong Length of Stay/LLOS
- End-of-life
- Independent, Dependent, and Inpatient vs. Outpatient

Management Issues in Hospice Care

In conducting this study, the researcher discovered that hospice care that is both appropriate and effective may be difficult to provide, particularly in circumstances where patients have a wide range of medical requirements. It may be challenging to hire and keep staff members who have the necessary skills for hospice work, especially in regions where there is a competitive job market for medical professionals. It is the responsibility of hospice providers to adhere to various rules, including the confidentiality of patient information, patients' safety, and the provision of high QOC (Johnston et al., 2020; Meier et al., 2017; Nagata et al., 2021).

Finance was another topic discovered in the research because government programs like Medicare or Medicaid often finance hospice treatment, and hospice providers still frequently face budget restrictions and other financial pressure, leading to management issues. Measuring and increasing patient satisfaction is essential to providing high-quality hospice care; this goal is never easy to accomplish due to the emotional and physical difficulties that patients and their families must endure **(**Deeley, 1999). Considering, the researcher concluded there were two critical themes within this study that directly concerned management issues; they were technology needs and communication processes.

Technology. Health IT and devices may be a plus or minus in the hospice care industry. For instance, incorporating technology into hospice care, such as telemedicine, may be difficult, particularly with regard to protecting patients’ rights to privacy and maintaining the integrity of their medical records.

Communication. It is essential to have effective communication between hospice workers, patients, and their families; nevertheless, this may also be challenging to accomplish, particularly in situations where patients have high levels of medical complexity or a limited ability to communicate in English. It may further be challenging to ensure that patients get adequate and coordinated treatment from various healthcare professionals, particularly in situations where patients simultaneously have many chronic illnesses. Also, providing good pain and symptom management is essential to hospice care; nevertheless, doing so may be difficult especially in situations where patients have complicated medical requirements. Although it is an essential component of hospice care, it can be challenging to meet patients and their families' emotional and psychological needs without effective communication in place. This is true particularly when patients are dealing with difficulties related to the end of life. Communicating encouragement and facilitating family engagement in hospice care is essential, which is particularly true when families cannot aid the patient on their own because of other obligations, such as work or other family responsibilities (Kogan et al., 2023).

Management Issues Obstructing Patient Care

Most of the participants in this study mentioned how expensive hospice service is; therefore, less expensive hospice care may provide cancer patients with several major advantages, including improved QOL. The goal of hospice care is to offer patients and their families comfort and support to enhance the remaining time they have together while also lowering levels of stress and worry, however the extraordinary cost of services is of major concern. Also, patients receiving hospice care are given access to comprehensive pain and symptom management, which enables them to control their symptoms better and hold on to their independence for as long as feasible but is also expensive for many people. Patients and their families further receive emotional and psychological support via hospice care, and each of these aids to patients and families for health and coping with the mental and physical obstacles of living with cancer should be more accessible to all than they currently are (Blackhall et al., 2016). Such findings show that hospice care is often coordinated to be provided by healthcare professionals, including doctors, nurses, social workers, and chaplains, who collaborate to give patients the necessary care and support. This kind of care is known as "coordinated care." Hospice care emphasizes family engagement and provides family members with the emotional and practical assistance they need to care for a loved one and deal with the emotional and practical challenges associated with the end-of-life process (Baragar et al., 2023). Considering the long-term benefits of hospice care for patients and their families is crucial. These benefits may include improved quality of life and reduced hospitalization and mortality rates. Although hospice care can be expensive, it is essential to consider these benefits as necessities as healthcare providers can improve the overall experience of cancer patients and their families, particularly when the professionals invest in hospice care training and standards that are centered on the patient. Research demonstrated that quality hospice care can help ensure cancer patients and their families receive the care and support they require throughout the process of dying (Laabar, 2022).

Quality Control and Patient Satisfaction

Assessing a cancer patient's needs is essential for maintaining high standards of care and ensuring their concerns are being met. In order to offer treatment that is tailored to each patient's specific requirements, hospice care practitioners must first conduct a comprehensive needs evaluation. Doing so has the potential to enhance patient outcomes and satisfaction with treatment. Hospice care practitioners may, for instance, (a) better manage patients' pain and other symptoms, (b) improve their quality of life, and (c) decrease their frequency of hospitalizations all by conducting a needs assessment. Patients and their loved ones may have a better quality of life and service experience characterized by less stress and anxiety if health care practitioners know the specific emotional and psychological assistance they need (Baragar et al., 2023).

Involving family members is essential for patient benefits since it is patients’ loved ones that primarily allow health care practitioners to effectively tailor their services to each person's treatment needs (Laabar, 2022). Health care practitioners may, therefore, improve the overall QOC and reduce the risk of duplicated or missing services by doing a complete evaluation of patient requirements and then coordinating care not only with other doctors and organizations, but also capable family members. Furthermore, it is essential to conduct regular evaluations of patient requirements to maintain the highest standards of care. Frequent needs assessments will allow hospice care practitioners to identify weak spots in their systems and procedures and make the required adjustments (Funk et al., 2023).

Finally, evaluation follow-ups should also be considered for improved QOC. Hospice care practitioners may also better fulfill their patients' needs and enhance their service quality by routinely evaluating patient outcomes and modifying treatment plans post needs assessments.

Such progress or status monitoring can boost patient happiness and health outcomes and decrease the likelihood of adverse side effects (Laabar, 2022).

Relationship Between Care Needs and Patient Satisfaction

Patient satisfaction is related to the QOC provided. However, this might look different for people with one form of cancer versus another. Nevertheless, patients with cancer are more likely to report high levels of satisfaction with their care if it is of high-quality, meaning tailored treatment that considers their unique physical, emotional, and social requirements (Jung et al., 2023). Conversely, dissatisfaction is more likely among patients who do not obtain enough treatment or believe their needs are not being effectively addressed. As patients with various forms of cancer may have distinct physical, emotional, and social demands, the type of cancer and its treatment may also impact patients' care needs and satisfaction levels.

Thus, hospice care practitioners must accurately identify and characterize each cancer patients’ specific care requirements to offer high-quality, patient-centered care (Komatsu & Komatsu, 2023). The (a) availability of support services, (b) quality of communication, (c) coordination between healthcare practitioners, and (d) general hospice atmosphere all affects a cancer patient's happiness with their care in relation to the level of tailored treatment they receive. Because of the physical, mental, and social difficulties that may occur during cancer treatment, patients with access to support services, such as social workers, dietitians, and rehabilitation experts, may be happier with their care. Patients are more likely to be satisfied with their healthcare when their physicians can effectively communicate and coordinate to offer them consistent, comprehensive treatment fit to their needs (Mosadeghrad, 2012).

A cancer patient's outlook on their treatment may be further influenced by the physical setting of the hospital, including the cleanliness and level of comfort of patient rooms. For instance, a patient's level of satisfaction with their treatment may increase if they can relax and feel at home in their hospital room, as opposed to a patient who cannot do so because of discomfort or a belief that their room is unclean care (Komatsu & Komatsu, 2023).

Finally, it is also worth noting that if a patient's health and care requirements change, their correlated satisfaction factors may shift as well. It is possible, for instance, for a patient's level of satisfaction with their care to decline as their demands evolve and the complexity of their treatment increases. In order to offer high-quality, patient-centered hospice care to cancer patients throughout their treatment, healthcare practitioners must continually analyze and understand their patients' changing care requirements (Laranjeira & Dourado, 2022).

Improvements Needed in Hospitals. Regarding hospice care in the United States, facility centers may have a few options for better serving their patients. With the help of multidisciplinary teams, hospitals can give patients effective treatment to meet their psychological, social, and spiritual requirements. In a patient-centered approach, the individual's goals and personal preferences for treatment are prioritized during the designing of hospice care plans. Involving patients in their care planning and providing individualized treatment are two ways to achieve this goal (Komatsu & Komatsu, 2023).

Electronic Health Record (EHR) implementation may boost patient safety and enhance treatment quality by facilitating better two-way communication and coordination between healthcare practitioners. Hospice centers can better manage cancer patient records by giving patients and their loved one’s access to a variety of support services, such as social workers, rehabilitation specialists, and support groups to help them deal with the psychological, physiological, and social effects of cancer treatment and thereby reduce recordkeeping complications. Creating and following standardized clinical pathways is one method to ensure that patients always get the best treatment possible, thus reducing their hospital time and increasing their likelihood of positive results.

Connectedly, hospitals may enhance the QOC they provide to cancer patients by frequently assessing their current procedures and monitoring patient outcomes for opportunities to enhance treatment. Healthcare professionals may better meet the requirements of cancer patients and increase their satisfaction with treatment if they are educated and trained on the newest developments in cancer therapy and the unique concerns and preferences commonly associated with them. The efficient treatment of cancer patients via high-quality, patient-centered care in the United States may be significantly improved by implementing these and other improvement measures (Komatsu & Komatsu, 2023).

Evidence-Based Care Interventions. The healthcare system in the United States has implemented various strategies, many of which are founded on scientific evidence, to improve the overall treatment experiences of cancer patients (Algorri et al., 2023). Surgical oncologists, radiation oncologists, and medical oncologists collaborate to give cancer treatment patients the highest standard of care and the best potential outcomes. As a part of high QOC for cancer patients, they are more often allowed to participate in the decision-making process and have a voice in their cancer treatment (Lupo et al., 2018).

Integrative medical practices such as acupuncture, massage, and mindfulness meditation are just some of the practices used to reduce the pain experienced by cancer patients and enhance their overall QOL. Cancer patients today also have increased options for taking part in research studies that examine potentially beneficial new treatments. Hospice care, which aims to reduce pain and enhance patient and family QOL, is increasingly incorporated into cancer therapy, starting with diagnosis. Hospice care was first developed in the 1970s. One of the many good results related to hospice care methods is an improvement in patients' degree of satisfaction with cancer treatment, as well as a decrease in the severity of symptoms (Algorri et al., 2023).

The link between intensive hospice care and aggressive symptom control is complicated and contentious, as is the influence of this relationship on the QOC provided. While hospice patients need active symptom management to alleviate suffering and enhance QOL, such management may also lead to overtreatment, which can result in unwanted side effects and increased expenses among other issues. In fact, the provision of intensive hospice care may burden available resources *and* cause burnout among hospice caregivers (Koch & Jones 2018).

On the other hand, it is essential to remember that providing high-quality hospice care is not limited to active symptom management or intensive care. Holistic care that attends to patient and family physiological, emotional, spiritual, and social needs and concerns is one of the defining characteristics of high-quality hospice care. Efficient communication and coordination of care between hospice teams, other medical professionals, and the community is required to enable a smooth transition from one kind of care to another. It is also important to note that the goal of hospice care is not to prolong a patient's life, but rather to focus on providing patients and families support and comfort while they deal with a terminal disease. Instead of concentrating on how long someone can live, hospice care providers work to improve their overall QOL.

In conclusion, in the approach to improving QOC, there is no simple solution to potential associations between patients receiving hospice treatment and leadership management. Hence, the overall approach to patient care and the coordination of services are two of the most critical factors defining hospice care quality.

The Problem

The general problem addressed in this study was managerial failure to provide high-quality hospice care in U.S. healthcare facilities, resulting in QCI and customer dissatisfaction within hospice centers (Jacobs & Shulman, 2017; Osagiede et al., 2018; Pesut et al., 2020). The central problem had a clear model that prioritized positive patient outcomes through provision of compassionate care to patients (Lawler et al., 2020). Thus, the general problem of management's failure to provide high-quality hospice care in healthcare facilities and the resulting QCI dealt with customer dissatisfaction. The findings from this study showed many agencies need improvement in the QOC they provide to cancer patients.

The researcher found that ineffectiveness, safety issues, and supervision process problems exist within the U.S. hospice industry. Undoubtedly, the outcomes of poor-quality care can be alarming for any hospice center. Variables that played a role in this study depended on the quality-of-service patients received. Many cancer patients in the United States often do not have access to appropriate, quality diagnosis and treatment, creating QOC failure at the outset of services (World Health Organization, 2021a). Healthcare administrators, doctors, and nurses and the role they play in saving lives cannot be understated. The researcher, therefore, concentrated research applications on finding practical solutions to the problems of hospice management. From a practical application standpoint, compassionate home medical services implemented with the help of family members can best enhance QOL for dying patients. In the end, God calls His soul to a spiritual place.

Another study finding concerned management and patient QOC which showed that individual health insurance can mitigate or worsen cost uncertainty. Financing the rising cost of healthcare is challenging for many U.S. Americans and demands difficult tradeoffs be made for governmental offices and families, especially those paying the bills. Healthcare is also highly complicated and specialized in the United States, making it challenging to meet treatment objectives, especially for inpatient hospice centers. The data could be widened in this study, however, the amount collected offers a good sense of the problems with cancer patient hospice care. For instance, management design was shown to be a fundamental element of high-quality hospice care, and the location of obstructions to high QOC across intermediary management points to independent, for-profit hospice facilities over dependent, nonprofit centers (e.g., see Boros, 2021).

Furthermore, participants expressed that dependent hospice centers or public hospitals seemed to have enough staff, nurses, and physicians necessary to support better QOL for cancer patients. However, quality control in centers and customer satisfaction among cancer patients are both better in the outpatient services area because of greater perceived compassion and family involvement. These observations indicate that the ownership model may have a meaningful correlation to cancer hospice services, although more organizations are charged with the provision of end-of-life care.

Summary of the Findings

In conclusion, the administration of hospice care is an essential component of end-of-life care, which calls for an all-encompassing, multidisciplinary strategy to meet the requirements of patients, their families, and an ever-evolving healthcare system. Hospice care management programs can ensure that all individuals have access to high-quality, compassionate end-of-life care by concentrating on (a) patient and family education and support, (b) quality care and patient safety, (c) spiritual and emotional support, and (d) the impact on available health care resources within the general healthcare system and respective hospice centers.

This MMR study combined objectively reported experiences of chronic illness alongside statistically analyzed data on symptoms to provide a greater understanding of the complexities involved in implementing high-quality hospice care into U.S. healthcare systems with inefficient management processes or resources. The management of symptoms, the practices involved in hospice care, and the provision of emotional and spiritual solace are all included in this complex area of healthcare. Overall, this research corroborates that there exists a knowledge gap in hospice management and leadership skills regarding diverse cancer patient needs in terms of race and culture, veteran experience, and medical device usage for all.

This study was centered on (a) examining the elements that influence the decision-making process of hospice leadership, (b) exploring the relevant conditions for cancer patient satisfaction with inpatient versus outpatient hospice services, and (c) enhancing the decisions and procedures made and implemented, respectively, in response to policymaking and medical IT producers, its results may assist patients and families, medical professionals and administrators, policymakers, and device producers. The major themes that the researcher discovered from participant responses concerning communication, emotional support, and the QOC for patients, veterans, and diverse communities constitute vital areas of hospice care that may benefit many.

Application to Professional Practice

This research and America's growing demand for hospice care demonstrate that any effort to improve the quality of end-of-life care is significant to the hospice industry. The research findings revealed that many Americans need proper knowledge of hospice services and quality healthcare. This study revealed that a relationship between management and intense hospice care to provide high-quality care does exist, and that there is a link between low-quality care and management issues. The researcher discovered that foundational variables linking to the research concepts shed light on a patient's need for outpatient versus inpatient hospice care services: the outcomes of patient responses to these medical services were examined through data obtained from quantitative surveys and qualitative questionnaires.

The research findings showed a connection that ineffective leadership was a management issue that contributed to patient outcomes within hospices in the United States, resulting in quality control issues and customer dissatisfaction (Jacobs & Shulman, 2017; Osagiede et al., 2018; Pesut et al., 2020). Participant responses from this study highlighted three main focuses:

1. Management issues impact overall patient outcomes and/or job dissatisfaction and corresponding worker conduct (i.e., turnover, burnout, and performance)
2. Leadership failure affects quality control factors.
3. Customers expressed dissatisfaction with management, leadership styles, and standards.

These findings primarily show the need for better patient care, and a need for better administrative support for effective medical management by (a) involving second-party vendors for medical devices, (b) contracting nurses for in-home services, and (c) assisting families at home with needs for food and shelter, safety, security, esteem, and self-actualization of the patient and family as predicted by Maslow (1943, as cited in Dohlman et al., 2019). The results of this study affirmed previous research. This study's participants mentioned areas of angst pertaining to educational and emotional support opportunities for training or training materials, financial requirements, home medical equipment, software (e.g., medical devices) and health information technology, and specific Veterans' concerns.

Improving General Business Practice

The leadership problem in question was management issues that contribute to patient outcomes within hospices in the United States, resulting in QCI and customer dissatisfaction (Jacobs & Shulman, 2017; Osagiede et al., 2018; Pesut et al., 2020). In many ways, the contributions and findings in this study will help improve the general business practice in the hospice industry. These discoveries presented critical general business practices related to developing guidelines in the hospice industry. These guidelines center on the research findings, such as happiness and actual well-being regarding holistic human needs, which were captured from the hospice participant’s surveys. Each participant in the interview openly expressed their innermost feelings; this approach shows the research concept of Maslow's self-actualizing strategy that is founded on individual development. Maslow asserted this concept as the final stage in an individual's linear growth. Maslow believed that to attain this state of personal completion, the individual must first fulfill the primary needs (i.e., physiological, safety, love/belonging, and esteem, in that order). Marlow contested that self-actualized individuals possess several characteristics (Ventegodt et al., 2003). Thus, the researcher considered each leadership management participant's self-actualization in meeting the research concept. The qualitative and quantitative findings are discussed below as how each contributes to improving general business practice. Using quantitative and qualitative data provides a more explicit meaning to the reader.

Quantitative Findings

Wang et al. (2023) argued that the psychological analysis approach improves organizational performance and effectiveness in hospice care. The review of the findings evaluates the development of performance appraisals and contends that the crucial area of line management development, which was identified as a critical success factor in appraisals, has been ignored for many decades. This study shed light on these ignored impacts of the hospice industry and the QOC system on the dynamism of numerous Americans. The majority of the study participants, 82 out of 96 respondents, indicated in the quantitative portion of the research that hospice industry management and attention to positive, relevant relationships were linked to aggressive symptom control and increased support of patients wishes and medication needs. Notably, the link between the care demands of various cancer patients and patient satisfaction and the dependability of data for internal control success are essential management challenges affecting the quality of hospice care provided. According to the study results, the quantitative findings discovered that some patients receiving hospice care at home were given medication to address the chronic pain they were experiencing. In turn, hospice outpatient care was a better fit for end-of-life patients than inpatient care, due to a greater focus on controlling pain medication, family support, and better financial support.

Participants I5, I9, I10, I64, and I65 played fundamental roles as leaders, doctors, and nurses in response to vital management issues in serving cancer patients. These participants indicated that leaders sometimes face confines that they are unable to manage to some extent and that management problems (e.g., staffing, rising healthcare costs, technology, etc.) significantly contribute to the care of hospice patients. Another remarkable result was the number of veterans surveyed in the study who have been overlooked. Many ended up in private hospice centers or did not meet the qualifying VA terms. Participants I1, I3, I22, I30, I31, I33, I43, I45, I46, I51, I56, I67, I73, I75, I78, I80, I82, I83, I84, I87, I88, I89, I93, I95 and I96 were veterans. A total of 25 participants gave their service to this research and to this country. The result is remarkable when it is considered that the course of business practices has forgotten our veterans and the promise has been broken, that we as the people or country would never forget our veterans. American veterans have never let their country down, and the healthcare industry should not let them down. Let us all today reaffirm these words and thank our veterans and their families for shouldering the weight of our country. The research findings demonstrated the need for better hospice care leadership. Hence, regulatory entities, and healthcare organizations, can leverage the conclusions of this study to match the need for improvement.

Qualitative Findings

In the qualitative portion of this mixed-methods study, practicing business themes emerged such as *Culture of Care*, *Training or Training Materials*, *Emotional Support*, *Veteran Care*, *Motivation Management Leadership Style*, *Financial Security*, *Communication*, and *Staff Burnout*. Participants spoke candidly in Phase II, and each participant provided a charismatic and detailed personal interview. Many of the research participants (79 out of 96 respondents) indicated the need to understand the process of hospice care, technology, emotional needs, and financial costs. Participant I35 recounted how illness that goes untreated can result in a person needing hospice care and can lead to other factors such as increased emotional needs, onset of false hopes, and eventually the end of life. Several emergent themes displayed the charismatic concept of devotion, especially in the outpatient participant interviews where caregivers expressed a need to provide ongoing commitment to family and emotional support to their dying ones. The study findings also confirmed there is a financial burden related to hospice care, particularly for the veteran participants in the study. The participants' responses in this qualitative phase reinforce the notion that leadership is a critical element of operating a hospice facility. Dohlman et al. (2019) and Newman and Schwarz (2018), asserted that motivation management leadership style is one that permits administrators to form and identify the demand for change while building patient satisfaction. This researcher concludes that there is a definitive answer as to how to lead management in the hospice industry for cancer patients: Leadership must be motivational, and they must listen to patients and employees.

Potential Application Strategies

Potential application strategies that organizations can use to leverage the findings of this study include hospice quality of care and leadership design. For example, leveraging an effectual hospice care strategy for healthcare can be transformed toward a people-centered, integrated, and technology-enabled healthcare system. It is clear, based on these research findings, that individuals with cancer have an undue burden. That burden is the worry about quality of care and the desperate hope for a cure for cancer. As a result of these identified burdens, potential application strategies can be geared toward cancer patients. Sackett (1997) discussed evidence-based medicine and its philosophical roots in making decisions regarding the care of individual patients. The practice of evidence-based medicine means combining individual clinical expertise with the best available outpatient services. Such focus lines up with this study's findings and helps in increasing expertise that reflects hospice business practice in many ways, especially in a more practical, compassionate, and effective identification and use of individual patients' predicaments, rights, and selections when making decisions about their care.

This study investigated multiple elements within the failure of the management process in the hospice industry. Past research has identified multiple public health advisories that recognize the importance of early prevention (Jacobs & Shulman, 2017; Osagiede et al., 2018). An example of early prevention value was found in the quantitative Phase I data, which demonstrated several inpatient circumstances in which pain and acute symptoms needed to be attended to in a specified hospice facility, such as a Medicare-certified hospital, hospice inpatient facility, or Veteran facility. In such circumstances, the nursing staff management needs to enforce unique quality patient care for cancer patients. Leadership must know how to best meet the needs of the dying and their grieving family. These research findings can be leveraged by healthcare management to design targeted, practical care approaches. Hospice leadership management should be ready for the changes that will come with the initiative. One particular finding pertains to staff burn out for hospice nurses trying to sustain an increased pressure to meet the physical needs and the demands of high quality of care. The intricacy of these demands for cancer patients during their end-of-life care creates a massive level of turmoil, anxiety, and worries of failure associated with the cancer process. To meet the potential application strategies the study discloses two essential components: support from leadership management is crucial and an openness toward expert usefulness is required. It is essential all parties communicate a clear vision for why management support and expert usefulness are needed to improve hospice quality of service. Leadership within each hospice care association should be able to communicate their support and daily processes used to motivate staff, nurses, and other healthcare providers to buy into the strategy (Cordella & Poiani, 2021).

To meet these potential strategies asserted above, nurse leaders must realize that they have the power to impact and leverage the work environment. As in participants I5, I9, I10, I64, and I65, these front workers have vital roles as leaders in these findings and can create an atmosphere with structural empowerment while diminishing burnout and turnover. This study provides an understanding of how to increase frontline staff engagement and communication. Leaders must leverage these processes. Leaders who model engagement stimulate engagement among their working group. This study’s’ findings show that this engagement stimulation can help nurse leaders prioritize hospice care needs.

Nurse leaders must make a point of being visible and available. In this study, staff members talked about the appreciation they feel when they sense camaraderie with their nurse directors, specifically when they see them as "one of us." The team members of the workforce are more likely to be engaged when they find their work noteworthy. Employers should supply training sessions to build leverage; this leverage can provide emotional intelligence for leaders and the work team. By providing workers emotional intelligence training, leaders will be equipping them with the foundational mechanisms that can carry long-term success to their business and allow them to create a succession of influential leaders across all departments and levels (Tandon et al., 2020).

Although emotional intelligence was not identified as an anticipated theme in this research, emotional concepts emerged as a theme within the findings. Emotional intelligence plays a component in a leader’s capability to perceive, utilize, understand, manage, and handle emotions. The working class and staff members of the hospice industry must recognize emotions. These lessons can potentially leverage the fears of cancer hospice patients and provide insight for improved leadership designs. The Maslow theory maps the central tenets of emotional intelligence for the hierarchy of needs. It is also a psychological idea about what pushes human behavior and makes humans feel fulfilled. Maslow's theory points in this study that once basic healthcare needs and patient quality of care are met, leadership (nurses, doctors) can focus on achieving higher-level psychological needs, including their sense of belonging, self-esteem, and self-actualization (Swenson, 2022).

There needs to be more research on the implementation of hospice leadership and QOC hospice care settings, thus, this research can have vast practical implications for potential application strategies. This research can provide valuable practical guidance to leaders as they work on executing care for hospice care patients. Leadership and quality issues prompted this research; the research data showed that cancer patients' needs along with quality assurance were foremost on the minds of the participants surveyed and interviewed. More specifically, quality hospice care and effectual leadership are factors to be considered for potential application strategies for all hospice centers. For instance, nurses and doctors in vital positions can strategize these findings for staff and patients. Furthermore, the findings of this research relate to the literature on management topics, such as growing healthcare expenditures and staffing problems, which in turn affect hospice experiences (Marzal-Alfaro et al., 2020; Tandon et al., 2020). This application of Maslow's Hierarchy of Needs and the practical implications for potential application strategies will help propel hospice care toward becoming a comprehensive approach for individual hospice cancer patients, not just for survival but toward rehabilitation of pre-illness function of mind, body, spirit, and until God is ready to take the spirit.

Summary of Application to Professional Practice

The research study sample was pulled from a population of 1,300 individuals and the researcher randomly selected 96 participants. The findings of this study exemplified the problem with leadership management and quality of care in hospice care in the United States. In this examination, participant collection was comprised of Medicaid recipients, Veterans, and healthcare providers. This researcher identified the leading cause of management leadership problems within United States hospice systems through interviewing and surveying doctors, nurses, and hospice leadership. The study participants highlighted more than four factors corresponding to worker conduct (i.e., turnover, burnout, and performance) and how leadership failure affects quality control factors. The results of this study confirmed prior research findings within the literature reviewed. Study participants answered and provided replies regarding the need for educational and emotional support, opportunities for training or training materials, financial requirements, home medical equipment, software (e.g., medical devices) and health information technology, and the issues surrounding United States veterans in utilizing hospice care services.

Recommendations for Further Study

More and more medical procedures are being performed in the comfort of a patient's home, bringing a wider range of human participants, activities, and technological tools into industrial medicine. Reasons for this shift include (a) a growing demand for medical services, (b) an aging population, (c) a higher prevalence of chronic diseases, and (d) advances in medical technology, all of which have increased the likelihood of recovery from a number of serious illnesses and injuries, even in premature babies. The large number of veterans returning from war with severe injuries, and the prevalence of new technologies that have made previously impossible medical feats now possible for them and others, should also be considered by leaders in the hospice industry. Unfortunately, the hospice care presently provided is variable in terms of quality, efficiency, cost, and patient safety (Pullen et al., 2023).

The researcher’s mission was to investigate the significant shifts in hospice care delivery, including any associated difficulties from the standpoint of diverse human factors, although this is only one angle. The profound and ongoing changes in both healthcare practice and policy have always presented a complex combination of possibilities and challenges. Therefore, this researcher endeavored to centralize how the human factors approach may empower both care receivers and caregivers to achieve the goal of optimizing the safety and quality of hospice healthcare provided in the home.

Based on the findings and literature reviewed in this study, each analyzed through a human factor's lens, the researcher placed the suggested areas of improvement for the hospice care services received by patients in-home in the following categories:

- Home medical equipment and software (e.g., medical devices and health IT, etc.)
- Caregivers and those receiving care
- Residential healthcare settings
- Veteran care
- Leadership training
- Research and development

Human factors concepts and hospice expertise and research methodologies used for in-home and inpatient hospice care may be safer and more effective while contributing to cost reductions than outpatient services, even if many concerns associated with home and inpatient hospice health care go unaddressed. Because the recommendations from this research study cover such a wide range of topics related to in-home hospice healthcare and hospice inpatient healthcare (all equally important to the numerous groups that would be impacted), the researcher does not assign priorities among them.

Home healthcare technologies consist of home medical equipment and the associated IT. Thus, this researcher does suggest an order of priority for use of medical equipment and IT in hospice inpatient home service since the bulk of this study centered on care in hospice facilities. Hospice inpatient variability is terrible for patients in many ways; as aforementioned in the study's findings section, four suggestions for improvement are offered:

- Regulation of consumer health technology.

- Establishment of standards for the labeling of medical devices.
- Establishment of guidelines and standards for health IT.
- Enhancement of systems for reporting adverse events associated with medical devices.

The implantation of these suggestions will help make hospice care and technology more user-friendly, easier to learn, and therefore more successful regarding their intended purposes. It would also increase the quality of user input to policymakers and developers.

Determining which federal agency has regulatory responsibility over a specific technology, and which requirements must be satisfied to ensure the safe implementation of new technology may be particularly challenging for hospice leaders. For instance, device regulation in the United States is under the purview of the Food and Drug Administration (FDA), whereas health IT is overseen by the Office of the National Coordinator (ONC). Although regulatory authority is split, the border between medical devices and health IT is blurring, and systems and applications that combine the two are being created. The regulatory ambiguity over the oversight of these items needs to be clarified for industry leaders to ensure high-quality care.

Importantly, the researcher did not find overwhelming evidence that there needs to be more information necessary for developing safe and effective home-based technologies. To the contrary, the researcher was concerned about the lack of focus on creating devices that would appropriately and necessarily accommodate people with little or no training on how and when to use them. For example, inexperienced users who choose to Save or Cancel, do so without full awareness of the equipment capabilities, maintenance needs, or potential difficulties involved in adapting devices to their unique living situations. As technology in healthcare grows in importance, many users, particularly those with poor health literacy, cognitive disability, or little technological expertise, will face foreseeable problems.

As another example, many electronic healthcare ("e-health") apps have been created to make distant healthcare services more efficient. Depending on the user's level of expertise and the urgency of their message, computer-based care management systems could provide varying levels of guidance to users. Reminders and alerts to caregivers could range from those caring for themselves or other family members to highly experienced professional medical staff. However, there may be negative implications for recipient health and safety if these technologies or applications are disregarded or abused because of their complexity. Safe and effective home health technology may be developed by using current accessibility and usability principles, as well as user-centered design and validation methodologies. The exact sector in which a product fits may or may not be apparent, and it is vital to realize that the border between medical devices and health IT has been blurred because regulatory control has remained separate.

To better regulate, certify, and monitor healthcare applications and systems that combine medical devices and health information technology, the researcher recommends that the FDA and ONC work together. Governmental bodies should make it a condition of product certification that manufacturers provide proof that they used user-centered design and validation techniques and complied with current accessibility and usability criteria.

There is insufficient industry-generated advice for hospice healthcare IT product developers regarding product content, structure, accessibility, and usability, which hinders the development of improved electronic health records for patients—at both facility and personal levels. Regarding both individual health records and care receivers' use of electronic health records, data may now be disseminated without risk of loss (e.g., patient portals). Despite the significance of this new technology method, no mandates or standards have been established for minimum accessibility, functionality, nor nature of usage and mandates for patient information in either electronic or non-electronic media. Because of this, specific portals have been built using the capacity of medical charts to track a patient's condition over time.

New studies reveal that even college-educated health workers find it difficult, if not impossible, to make sense of data and portals built using this approach (Gowda, et al., 2021). Developers of Personal Health Records (PHRs) and patient portals (PP), therefore, need more direction in this area to prevent them from creating products that fail to meet users' actual demands. The researcher further recommends that the National Coordinator for Health IT, the National Institute of Standards and Technology, and the Agency for Healthcare Research and Quality collaborate to create guidelines and standards based on existing industry procedures for the content, accessibility, functionality, and usability of consumer health ITs related to home-based healthcare.

During the data-finding process of this study the researcher discovered a severe deficiency in acceptable standards and guidelines for labeling medical equipment. As a result, the researcher has learned that the FDA's approval procedures for modifying these components are lengthy and rigid. Although many people now utilize medical devices in the comfort of their own homes, these tools were initially developed and certified for use solely by specialists in institutional healthcare settings. The researcher acknowledges that when devices are used by individuals or groups for whom they were not designed, the degree of danger increases due to the absence of instructional materials or training for users. To this end, although manufacturers are aware they need to generate or amend instructional and training materials for lay users of devices that have previously been authorized and sold publicly, the existing FDA premarket review and approval procedures discourage producers from doing so (Gowda, et al., 2021).

Some administrators in this study were found to be altering the authorized instructions for devices used in their practice. This activity signals the need to resubmit the devices for new instructions approved by the FDA via a 510(k) premarket notice review. Despite the fact that this requirement may serve as a barrier to making necessary updates to developers' instructional or training materials it is a difficult, time-consuming, and costly evaluation. In addition, there is presently little information accessible to aid developers in designing medical devices for users.

Medical device training techniques and resources are being neglected. As extensive as the newly published human aspects standard on medical device design is (Association for the Advancement of Medical Instrumentation, 2023), it does not include training or training materials. While some current standards address the creation of labeling and subsequent instructions for usage, they fail to consider the most recent results from research on instructional systems design. Furthermore, existing standards do not account for the fact that healthcare workers as professional users of medical equipment have distinct needs in terms of training, training materials, and instructions for usage. Thus, the FDA should encourage the development of new standards for the labeling of devices and creation of instructional materials that consider the most recent human factors research by organizations like the American National Standards Institute, and the Association for the Advancement of Medical Instrumentation. The FDA should consider adapting and simplifying its approval procedures to make it easier for producers to upgrade.

Reflections

Developing a dissertation is usually a unique procedure that evolves; as a professor, business owner, and researcher for a nonprofit organization, this experience helped me to fully understand each task in the process. However, the researcher needed further clarification because Liberty University's business dissertation methodology differs from previous institutions attended. Thus, the University faculty and Chair of the program helped in the journey. After starting this dissertation process over three years ago, and with over 300 pages toward finishing the dissertation, reaching the ending is near; what is learned is the lesson of a lifetime. Also, the feeling of the young man in me became old after finishing this process. My hearing and eyes were not as sharp as before starting this dissertation, but by the end, my mind was more knowledgeable and wiser. Taking a moment to reflect and reassess at the end gives this study's phenomenon a unique focus. For example, the roadblocks and challenges only strengthened my resolve and inspired me rather than deterred me from seeking my goal. The mere fact that I could do this is what I learned.

Personal & Professional Growth

Developing and implementing this research dissertation provided a challenge that pushed me outside of my comfort zones of learning and allowed me to challenge myself in a way I have not done before. Doing so allowed me to challenge myself and bring the beliefs and values learned through this procedure to a more personal insight. I gained an in-depth understanding of my learning style and developed a renewed awareness in my roles as a professor, researcher, and business owner. Overall, the dissertation was inspiring and gave me a restorative route leading to a fuller personal and professional development. The research enabled this researcher to acquire crucial self-awareness in individual development. The study equipped this researcher to conduct significant academic studies in business and health management and sparked a vital interest in scientific research. From the beginning, this study evolved around a need to design a unique concept centered on developing and conducting a scientific survey in business management.

The journey in this dissertation was also one of development of self-awareness. During the writing of this dissertation self-awareness was critical in analyzing internal data and gathering appropriate external data. The researcher developed a gratitude for overcoming any initial doubt in beginning the journey and as each task was successfully completed gradually overcame lingering feelings of anxiety and inadequacy. This journey was separated into three unique stages. In the first stage the dissertation topic was surveyed, which activated the researcher's inner self to rehearse the process and to look at the big picture. In the second phase the researcher experienced a struggle to express the study's intent and sensible development using the chosen mixed method. During the third stage self-awareness increased due to the continuous practice of reviewing literature and exploring the outcomes from this research process.

The professional growth attained is essential in all of the researcher's personal and professional career phases. For example, in conducting self-study, the lens of critical theory was utilized to examine personal experiences, which highlighted that crucial research involves the empowerment of individuality. In my daily career, I engage in this self-study to enhance my professional growth skills and instruct my students through their learning. Chow et al. (2022) asserted that the focus on studying ourselves and on how to learn the central motivation is the purpose of our self-study. That motivation is also a theory that refers to a "school of thought" and a methodology of play-by-play that displays the involved forces affecting minoritized groups and personalities.

This philosophy also helped my growth with working on subjects concerning Covid-19, not only as a researcher from 2019 to the present but also in working on scholarly work and published articles. In light of Covid-19 with the Research Institution organization, we took on issues published as one of the first researchers to tackle the subject of Covid-19 in November 2019 and one of the first medical labs to test 8 participants in the Covid-19 samples within the United States (Obasun, 2020). There has been so much personal growth surrounding this dissertation process: in 2020, I was elected as a scholarly reviewer for scholars' articles for Sage Open Publication, Clarivate, and Scholar One. Words cannot express the depth of my personal growth, but glory to God for all that shall come.

Biblical Perspective

The business function explored in this study relates to integrating principles for the Christian worldview because it gives an insight into defining corporate functions to support an ethical strategy. The support and design give growth to health management and incorporate Biblical principles in the process of standards and ethics that give faith meaning.

Many hospice facilities already incorporate faith-based congregations, associations, and agencies as established parts of their ministry. Despite the broader differences in denominations, the perspective of faith plays a role in daily medicine and delineating the end-of-life process. The end-of-life process was an important topic in this study. The study explored the perceptions of 96 participants; some met death, and some neared their end of life. The tenet of religion and business practice implies three dimensions in hospice care. The three dimensions play the same role as the research concepts (biological, psychological, and social) but do not explicitly exclude the spiritual dimension. The two words, *psychological* and *social*, are spiritual to each participant, regardless of their faith. Their physical presence gave each participant a sacred space where patients’ needs are articulated and need to be considered in the hospice concept of caring for patients. This difference is exemplified by the reality that, although all hospitals and all hospices offer chaplaincy services, the Pastor is not seen as an element of the clinical team but as an ancillary consultant in most locations (Lagman et al., 2021).

Anand et al. (2020) asserted a recognition process of religious concepts and broadened the idea of business practice into whole-person medicine. Furthermore, the process encompasses four overlapping elements of research, biological, psychological, social, and spiritual. These results signify that healthcare professionals should agreeably understand the patient's personal, cultural, and religious values. Biblical principles guide our decisions in life or practice management. Leadership should value the relevancy of the biblical tenets because they inform employees in day-to-day functions (Methuen, 2017).

The Bible's views in this arena of health management are vital. Effective management demands the capability to think, learn, and instruct all people. Applying QOC processes with the biblical principle also starts with the recruitment, staff, and management processes (Sileyew, 2020). The findings from this study can be incorporated in a systematic and orderly fashion in the daily workday for hospice care. Scriptural doctrines guided the current study in the hospice management design to embrace a process that yields reproducibility and faith in the day-to-day decisions driven by managers. Many of the finding’s themes included spiritual/religious responses. Being with dying patients is vital to hospice services, yet numerous doctors, nurses, and leadership need to prepare to accompany individuals through their end of life. Based on the interview and survey findings, participants mention listening as a means of staying present. Patients can be emotionally challenging because the doctors, nurses, and leadership must show vulnerability when meeting a patient’s end of life limitations.

The findings also reveal that many terminally ill hospice patients experience a need for various levels of spiritual care and counseling (Sileyew, 2020). Richards et al. (2021) asserted that the fast-paced hospice care domain views death as a physiological event, a natural component of the human lifecycle, and a religious course of life. Easing and relieving suffering is at the heart of hospice services. It is also part of the primary care aspect; the idea of suffering incorporates the dying patient's entire experience of life physically, mentally, and spiritually. This finding in the study indicates that many ill cancer and hospice patients are experiencing spiritual and existential matters and long for proper spiritual or existential care and counseling.

Nevertheless, the study reveals hospice care professionals lack skills in end-of-life patients' psychosocial and spiritual care, resulting in poor QOC, increased patient distress and grief, and staff burnout. The researcher repoints that even though the program in hospice services is linked to chaplain services, the hospice facility needs to analyze ways of being with the dying that can benefit both the caregiver and one’s end-of-life in a practical and spiritual manner. Therefore, the final results present a biblical view that is evenhandedness and illustrates a statement to the biblical concept and the hospice industry. These views are significant to a deeper understanding of the hospice management experience and the emotional meanings of their experiences.

Summary of Reflections

The research findings will help close the gaps surrounding efficacious care within the hospice industry and help increase knowledge in the areas of hospice leadership. For individuals facing a terminal disease’s end stages, hospice care can aid in reducing discomfort, pain, and additional symptoms. This end-of-life care can help people live their final days as thoroughly and comfortably as possible.

While doctors can treat symptoms, hospice care teams also communicate with families to support their loved ones in making a difficult decision regarding end-of-life care. Hospice care staff administer care, emotional support, and most of all tend to an individual’s spiritual needs as they need human love and the love of God before their death.

In summary, my personal & professional growth allowed me to grow and learn in several areas of my life. My personal growth in this dissertation helped develop my self-awareness. I also utilized the lens of critical theory to examine my experiences, highlighting crucial outcomes of this research involving the empowerment of individuality. In my daily career, I engage in this self-study to enhance my professional role in becoming a better scholar and business owner.

Finally, although a vital tenet of being a Christian is embracing basic biblical principles, this study showed those tenets. It incorporated them into the worldview of hospice care by processing the study into collaboration and commitment. Further, evidence from the interview and survey responses to the questionnaire show correlating themes. It is hoped that the findings of this research will help the hospice industry close the historical literature gaps.

Summary of Section 3

The objective of the mixed methods research (MMR) was to address management's failure to give high-quality hospice care in healthcare facilities. Failure to provide high-quality care leads to issues with quality control and customer satisfaction in hospice centers (Jacobs & Shulman, 2017; Osagiede et al., 2018; Pesut et al., 2020). The researcher applied an MMR method to execute a routine survey with 96 participants in select U.S.-based hospice services management facilities. Medical records from the Research Institution organization between November 2022 and March 2023 were used to select participants for this study. The total population selected was 1,300 and out of that population 96 participants were randomly selected.

This study's first phase included surveying participants using questions that yielded quantitative responses. The second phase involved a systematic procedure using open-ended questions designed to extract thoughtful answers from the participants.

The researcher followed the theoretical model proposed by Abraham Maslow (Dohlman et al., 2019), which implies that individuals have developed needs and goals, beginning with fundamental physiological requirements such as food and shelter and then progressing to feelings of safety and security, esteem, and eventually self-actualization. Maslow's (Dohlman et al., 2019) theory was a starting point for this research examination. The study results indicate improving leadership and administration of healthcare institutions in the United States is critical and it is equally crucial to address the quality of hospice care available to cancer patients.

The data collected demonstrates the challenges leaders face in hospice care, exhibiting no signals of slowing down. The finding in the study reveals dissatisfaction among nurses, doctors, leaders, and patients. The research permitted the researcher to offer new or improved suggestions for methods and designs in the current realm of quality patient care, which may improve worker satisfaction, and enhance leadership management. The current findings demonstrate that effectual leadership management assures workers effectiveness and motivation, creates inspiration and encouragement, thereby delivering effective communication to workers in a way that facilitates them intellectually and helps in the process of daily participation.

Hospice utilization continues to rise nationwide; the finding in this study reveals that hospice professionals need communication essentials and is directly linked to academic literature findings; for example, within this study, the literature review and finding show motivation was asserted through factors utilizing Maslow's leadership management theory. Management leadership hinges on those factors, the everyday working circumstances. These everyday circumstances played a role in the veteran participants in this study in elements of service provided to them. Some were getting transferred from facility to facility, causing communication barriers in discussing hospice care and utilization decisions. Participant I1 and I35, respectively shared about doctors providing orders for medication management for some and not others, and physicians not allowing a blood transfusion for the patient during their end-of-life cycle: this pleads the question of why a doctor can play God with other people's lives. Overall, the study finds confirmation within the current literature collections. In that, individuals in an inpatient hospice service are significantly more likely to be disenrolled from hospice following a long enrollment period than those individuals in outpatient hospice services. The provision of quality hospice care hinges on the leadership and management that each facility provides to alleviate their patient's pain toward entering a place of hope, and eventually the spirit world.

Summary and Study Conclusions

The researcher conducted the current study to address management's failure to give high-quality hospice care in healthcare facilities. Failure to provide high-quality care leads to issues with quality control and customer satisfaction in hospice centers (Jacobs & Shulman, 2017; Osagiede et al., 2018; Pesut et al., 2020). The researcher used an MMR method to complete a standard survey and interviewed 96 participants in select U.S.-based hospice services management facilities—the results of this study aid in addressing gaps in the literature. These gaps were shown in the study's findings concerning how the quality of the patient can be administered to address management's failure to give high-quality hospice care in healthcare facilities. Doctors, nurses, and leadership would benefit from implementing the study's recommendations. Implementing the recommendations will also create an emergent platform of interactions between leadership and patients. The recommendations will assist in fostering the enhancement of technical skills and expertise to foster an atmosphere of an amplified standard on training and workforce. Improving and training professional expertise between management and patients will sufficiently prepare both professionals to meet and address the challenges arising from hospice facilities. The training will subsequently assist in constructing sounder and more knowledgeable procedures to safeguard hospice patients in entrusting confidence in the United States hospice industry. Other healthcare industries in the United States or similar lines of industry on the international phase can learn from the study's outcomes and apply the study conclusions to amplify their awareness of the factors closely associated with hospice management.

References

Abel, G.A., Gomez-Cano, M., Pham, T.M., & Lyratzopoulos, G. (2019) Reliability of hospital scores for the cancer patient experience survey: Analysis of publicly reported patient survey data. *BMJ Open, 9* (7). https://doi.org/10.1136/bmjopen-2019-029037

Abualoush, S. H., Obeidat, A. M., Tarhini, A., Masa'deh, R., & Al-Badi, A. (2018). The role of employees' empowerment as an intermediary variable between knowledge management and information systems on employees' performance. *VINE Journal of Information and Knowledge Management Systems*, *48*(2), 217–237. https://doi.org/10.1108/vjikms-08-2017-0050

Abu-Odah, H., Molassiotis, A., & Liu, J. (2020). Challenges on the provision of palliative care for patients with cancer in low-and middle-income countries: A systematic review of reviews. *BMC Palliative Care*, *19*, 1-16. https://doi.org/10.1186/s12904-020-00558-5

Aguirre Polanco, A. (2018). *The adoption of disruptive innovations in local health care agencies delivering primary care*. [Doctoral dissertation, The University of Texas at El Paso]. ProQuest. https://scholarworks.utep.edu/open_etd/1391/

Albuquerque, P. C., Zicker, F., & Fonseca, B. P. (2022). Advancing drug repurposing research: trends, collaborative networks, innovation, and knowledge leaders. *Drug Discovery Today*, 103396. https://doi.org/10.1016/j.drudis.2022.103396

Alexanian, J., Fraser, I., Smith, O., & Kitto, S. (2021). Defining and redefining family involvement in practice: An implementation trial of a locally adaptable patient-centered professional development tool in two Ontario intensive care units. *Journal of Continuing Education in the Health Professions, 41*(4), 253-262. https://doi: 10.1097/CEH.0000000000000402

Alharahsheh, H. H., & Pius, A. (2020). A review of key paradigms: Positivism VS interpretivism. *Global Academic Journal of Humanities and Social Sciences*, *2*(3), 39-43. https://doi/org/10.36348/gajhss. 2020.v02i03.001

Al-Hussami, M., Al-Momani, M., Hammad, S., Maharmeh, M., & Darawad, M. (2017). Patients' perception of the quality of nursing care and related hospital services. *Health and Primary Care, 1*(2). https://doi.org/10.15761/hcp.10000110

Almeida, F. (2018). Strategies to perform a mixed-methods study. *European Journal of Education Studies, 14*(1). https://doi.org/10.5281/zenodo.1460214

Amin, M. E. K., Norgaard, L. S., Cavaco, A. M., Witry, M. J., Hillman, L., Cernasev, A., & Desselle, S. P. (2020). Establishing trustworthiness and authenticity in qualitative pharmacy research. *Research in Social and Administrative Pharmacy*, *16*(10), 1472-1482. https://doi.org/10.1016/j.sapharm.2020.02.005

Amini Farsani, M., Babaii, E., Beikmohammadi, M., & Babaii Farsani, M. (2021). Mixed-methods research proficiency for applied linguists: A PLS-path modelling approach. *Quality & Quantity*, 126. https://doi.org/10.1007/s11135-021-01268-7

Anand, T. S., Anand, S. V., Welch, M., Marsick, V. J., & Langer, A. (2020). Overview of transformative learning I: Theory and its evolution. *Reflective Practice*, *21*(6), 732-743. https://doi.org/10.1080/14623943.2020.1821942

Aron, A., & Aron, E.P. (1997). *Statistics for the social and behavioral sciences: A brief course*. Prentice Hall. http://www.psychology.stonybrook.edu/aronlab-/people/art.htm

Ashworth P., (2003). An approach to phenomenological psychology: The contingencies of the lifeworld. *Journal of Phenomenological Psychology*, *34*(2), 145-156. https://doi.org/10.1163/156916203322847119

ASCO. (2016). The state of cancer care in America, 2016: A report by the American Society of Clinical Oncology. *Journal of Oncology Practice*, *12*(4), 339–383. https://doi.org/10.1200/jop.2015.010462

Association for the Advancement of Medical Instrumentation. (2023). Sterilization of health care products—radiation sterilization—substantiation of 25 kgy as a sterilization dose—method vdmax. *AAMI Technical Information Report*, *A4:2020*. http:// www.aami.org/standards/ansi-aami-st79

Bainbridge, D., & Seow, H. (2018). Palliative care experience in the last three months of life: A quantitative comparison of care provided in residential hospices, hospitals, and the home from the perspectives of bereaved caregivers. *American Journal of Hospice and Palliative Medicine*, *35*(3), 456-463. https://doi.org/10.1177/1049909117713497

Bagnasco, A., Rosa, F., Dasso, N., Aleo, G., Catania, G., Zanini, M., & Sasso, L. (2021). Caring for patients at home after acute exacerbation of chronic obstructive pulmonary disease: A phenomenological study of family caregivers' experiences. *Journal of Clinical Nursing*, *30*(1516), 2246-2257. https://doi.org/10.1111/jocn.15613

Bakitas, M.A., Tosteson, T.D., Li, Z., Lyon, K.D. Hull, J.G., Li, Z., Dionne-Odom, J., Dragnev, K.H., Hegel, M. T., Azuero, A., & Ahles, T. A. (2015). Early versus delayed initiation of concurrent palliative oncology care: Patient outcomes in the ENABLE III randomized controlled trial. *Journal of Clinical Oncology*, *33*(13), 1438-1445. https://doi.org/10.1200/JCO.2014.58.6362

Bally, J. M., N. R., & Burles, M. (2019). Pediatric palliative and hospice care in Canada. *Hospice Palliative Home Care and Bereavement Support*, 253-269. https://doi.org/10.1007/978-3-030-19535-9_19

Baragar, B., Schick-Makaroff, K., Manns, B., Love, S., Donald, M., Santana, M., Corradetti, B., Finlay, J., Johnson, J.A., Walsh, M., & Elliott, M.J., (2023). “You need a team”: Perspectives on interdisciplinary symptom management using patient-reported outcome measures in hemodialysis care—a qualitative study. *Journal of Patient-Reported Outcomes*, *7*(1), 1-14. https://doi.org/10.1186/s41687-022-00538-8

Bates, D. W. (2009). The approaching revolution in quality measurement. *The Joint Commission Journal on Quality and Patient Safety*, *35*(7), 358. https://doi.org/10.1016/s1553-7250(09)35050-3

Batstone, E., Bailey, C., & Hallett, N. (2020). Spiritual care provision to end-of-life patients: A systematic literature review. *Journal of Clinical Nursing*, *29*(19-20), 3609-3624. https://doi.org/10.1111/jocn.15411

Beattie, M., Murphy, D. J., Atherton, I., & Lauder, W. (2015). Instruments to measure patient experience of healthcare quality in hospitals: A systematic review. *Systematic Reviews*, *4*, 97. https://doi.org/10.1186/s13643-015-0089-0

Bergerød, I. J., Dalen, I., Braut, G. S., Gilje, B., & Wiig, S. (2020). Measuring next of kin satisfaction with hospital cancer care: Using a mixed-method approach as basis for improving quality and safety. *Journal of Advanced Nursing*, *76*(5), 1232–1246. https://doi.org/10.1111/jan.14315

Bern-Klug, M., Carter, K. A., & Wang, Y. (2021). More evidence that federal regulations perpetuate unrealistic nursing home social services staffing ratios. *Journal of Gerontological Social Work*, *64*(7), 811-831. https://doi.org/10.1080/01634372.2021.1937432

Best, C. (2020). Patient satisfaction metrics. In: Salem, D. (eds) *Quality measures.* Springer Cham. https://doi.org/10.1007/978-3-030-37145-6_9.35

Best, K., & Ingram, D. H. (2020). Five months later: The psychodynamic psychiatrist and psychiatric care in the era of covid-19. *Psychodynamic Psychiatry*, *48*(4), 363-39. https://doi.org/10.1521/pdps.2020.48.4.363

Bist, R. B. (2014). Research procedure: An introduction. *Journal of NELTA Surkhet*, *4*, 34-40. https://doi.org/10.3126/jns.v4i0.12858

Black, A., McGlinchey, T., Gambles, M., Ellershaw, J., & Mayland, C. R. (2018). The 'lived experience' of palliative care patients in one acute hospital setting–a qualitative study. *BMC Palliative Care*, *17*(1), 1-10. https://doi.org/10.1186/s12904-018-0345-x

Blackhall, L. J., Read, P., Stukenborg, G., Dillon, P., Barclay, J., Romano, A., & Harrison, J. (2016). CARE track for advanced cancer: impact and timing of an outpatient palliative care clinic. *Journal of Palliative Medicine*, *19*(1), 57-63. https://doi.org/10.1089/jpm.2015.0272

Bloomfield, J., & Fisher, M. J. (2019). Quantitative research design. *Journal of the Australasian Rehabilitation Nurses Association*, *22*(2), 27. https://doi.org/10.3316/informit.738299924514584

Booth, T. (2018). Mapping inclusion and exclusion: Concepts for all? In *Towards inclusive schools?* (pp. 96108). Routledge. https://www.taylorfrancis.com/chapters/edit/10.4324/9780429469084-8/mapping-inclusion-exclusion-concepts-tony-booth

Bormann, K. C., & Rowold, J. (2018). Construct proliferation in leadership style research. *Organizational Psychology Review*, *8*(2-3), 149–173. https://doi.org/10.1177/2041386618794821

Boros, C. (2021). *Marketing the environment: A for-profit vs. Nonprofit approach* [Master's thesis, Toronto Metropolitan University] https://doi.org/10.32920/ryerson.14662302

Brannen, J. (2005). Mixing methods: The entry of qualitative and quantitative approaches into the research process. *International Journal of Social Research Methodology*, *8(*3), 173-184. https://doi.org/10.1080/13645570500154642

Brom, H., Anusiewicz, C. V., Udoeyo, I., Chittams, J., & Brooks Carthon, J. M. (2021). Access to post-acute care services reduces emergency department utilization among individuals insured by Medicaid: An observational study. *Journal of Clinical Nursing*. https://doi.org/10.111/jocn.15932

Brothers, B.M., Yang H. C., Strunk, D. R., & D. R., & Anderson, B. L. (2011). Cancer patients with major repressive disorder: Testing a biobehavioral/cognitive behavior intervention. *Journal of Consulting and Clinical Psychology*, *79*(2), 253. https://doi.org/10.1037/a0022566

Buchbinder, S. B., Shanks, N. H., & Kite, B. J. (2021). *Introduction to health care management*. Jones & Bartlett Learning. https://online.vitalsource.com/#/books/9781284119725/cfi/6/4!/4/2/4@0:16.1

Buchbinder, S. B., Shanks, N. H., & Kite, B. J. (2019). *Introduction to health care management*. Jones & Bartlett Learning. http://samples.jblearning.com/9781284156560/9781284156645_CH01_Pass03.pdf

Buchheit, S., Doxey, M. M., Pollard, T., & Stinson, S. R. (2018). A technical guide to using Amazon's Mechanical Turk in behavioral accounting research. *Behavioral Research in Accounting*, *30*(1), 111-122. https://doi.org/10.2308/bria-51977

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., & Walker, K. (2020). Purposive sampling: Complex or simple? Research case examples. *Journal of Research in Nursing*, *25*(8), 652-666. https://doi.org/10.1177/1744987120927206

Carmont, S. A., Mitchell, G., Senior, H., & Foster, M. (2018). A systematic review of the effectiveness, barriers, and facilitators to general practitioner engagement with specialist secondary services in integrated palliative care. *BMJ Supportive & Palliative Care*, *8*(4), 385-399. http://dx.doi.org/10.1136/bmjspcare-2016-001125

Carraher, S., Parnell, J. A., & Spillan, J. E. (2009). Customer service-orientation of small retail business owners in Austria, The Czech Republic, Hungary. *Baltic Journal of Management*, *4*(3), 251-268. https://doi.org/10.1108/17465260910990975

Cassel, J. B., Bowman, B., Rogers, M., Spragens, L. H., Meier, D. E., & Palliative care leadership centers. (2018). Palliative care leadership centers are key to the diffusion of palliative care innovation. *Health Affairs*, *37*(2), 231-239. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1122

Cella, D., Gershon, R., Lai, J. S., & Choi, S. (2007). The future of outcomes measurement: Item banking, tailored short-forms, and computerized adaptive assessment. *Quality of Life Research*, *16*(1), 133141. https://doi.org//10.1007/s11136-007-9204-6.

Centers for Disease Control and Prevention. (2021a, April 16). *Surveillance Case Definitions*. Centers for Disease Control and Prevention. https://www.cdc.gov/nndss/conditions/notifiable/2021/

Centers for Disease Control and Prevention. (2021b, June 8). *About the databases*. Center for Disease Control and Prevention. https://www.cdc.gov/cancer/uscs/public-use/about.htm

Chan, H. Y., Lee, D. T., & Woo, J. (2020). Diagnosing gaps in the development of palliative and end-of-life care: A qualitative exploratory study. *International Journal of Environmental Research and Public Health*, *17*(1), 151. https://doi.org/10.3390/ijerph17010151

Chen, E.K., Ahluwalia, S.C., Shetty, K. Pillemer, F., Etchegaray, J.M., Walling, A., Kim, A. Y., Martineau, M., Phillips, J., Farmer, C.M., & Ast, K. (2021). Development of palliative care quality measures for outpatients in clinic-based setting: A report on information gathering activities. *Rand Health Quarterly, 9*(2), 2. https://doi.org/10.72249/rr4273

Chow, C. J., Hirshfield, L. E., & Wyatt, T. R. (2022). Sharpening our tools: Conducting medical education research using critical theory. *Teaching and Learning in Medicine*, *34*(3), 285-294. https://doi.org/10.1080/10401334.2021.1946401

Citi. (2021). The trusted standard in research, ethics, and compliance training. https://about.citiprogram.org

Clark, V. L. P. (2019). Meaningful integration within mixed methods studies: Identifying why, what, when, and how. *Contemporary Educational Psychology*, *57*, 106-111. https://doi.org/10.1016/j.cedpsych.2019.01.007.

Claxton-Oldfield, S., Hicks, R., & Claxton-Oldfield, J. (2020). A pilot study evaluating the effectiveness of a training module designed to improve hospice palliative care volunteers' ability to deal with unusual end-of-life phenomena. *Omega--Journal of Death and Dying*, *85*(1), 75–87. https://doi.org/10.1177/0030222820935222

Collett, G. K., Durcinoska, I., Rankin, N. M., Blinman, P., Barnes, D. J., Anderiesz, C., & Young, J. M. (2018). Patients' experience of lung cancer care coordination: A quantitative exploration. *Supportive Care in Cancer*, *27*(2), 485–493. https://doi.org/10.1007/s00520-018-4338-3

Collins, K. (2010). Advanced sampling designs in mixed research: Current practices and emerging trends in the social and behavioral sciences. In *SAGE handbook of mixed methods in social & behavioral research* (pp. 353-378). SAGE Publications. https://dx.doi.org/10.4135/9781506335193

Cordella, M., & Poiani, A. (2021). Journey towards the end of life. *International Perspectives on Aging Fulfilling Ageing*, 721-890. https://doi.org/10.1007/978-3-030-60071-6_8

Cornelius, T., Birk, J. L., & Shechter, A. (2020). The prospective association of patient hospitalization with spouse depressive symptoms and self-reported health. *Behavioral Medicine*, 1-1. https://doi.org/10.1080/08964289.2020.1870431

Cross, L A. (2019). Compassion fatigue in palliative care nursing: A concept analysis. *Journal of Hospice and Palliative Nursing*, *21*(1), 21. https://doi.org/10.1097/NJH.0000000000000017

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. SAGE Publications.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative and mixed-method approaches* (4th ed.). California, SAGE Publications, Inc.

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage Publications, Inc.

Creswell, J. W., Plano Clark, V. L., Guttmann, M. L., & Hanson, E. E. (2003). *Advanced mixed methods research design*. Sage Publications.

Creswell, J. & Poth, C. (2018). *Qualitative inquiry & research design* (4th). Sage Publications, Inc.

Creswell, J. W., & Tashakkori, A. (2007). Developing publishable mixed methods manuscripts. *Journal of Mixed Methods Research, 1*(2). https://doi.org/10.1177/1558689806298644

Daher, P., Guillaume, Y. R. F., & Crawshaw, J. (2018). Tough leaders? The role of leader/follower gender and leadership style on leadership effectiveness. *Academy of Management Proceedings*, *2018*(1), 14148. https://doi.org/10.5465/ambpp.2018.14148abstract

Davis, M. (2016). Who pays for hospice care? Retrieved, 4 September 2021, from https://www.homecare.com/home-care-resources/paying-for-hospice

Davis, A., Repar, P., Wilson, M., De Luca, E., Doutrich, D., & Thanasilp, S. (2023). Transforming nurse self-care through integration of spirituality: Lessons from an international collaboration in palliative care. *Journal of Transcultural Nursing*, *34*(1), 91-99. https://doi.org/10.1177/1043659622113481

Davlyatov, G., He, M., Orewa, G., Qu, H., & Weech-Maldonado, R. (2023). Are hospice Google ratings correlated with patient experience scores? Evidence from a national hospice study. *American Journal of Hospice and Palliative Medicine*, 10499091231160186. https://doi.org/10.1177/10499091231160

Dawadi, S., Shrestha, S., & Giri, R. A. (2021). Mixed-methods research: A discussion on its types, challenges, and criticisms. *Journal of Practical Studies in Education*, *2*(2), 25-36. https://doi.org/10.46809/jpse.v2i2.20

Dawson, W. D., Boucher, N. A., Stone, R., & Van Houtven, C. H. (2021). COVID-19: The time for collaboration between long-term services and supports, health care systems, and public health is now. *The Milbank Quarterly*. https://doi.org/10.1111/1468-0009.12500

Deeley, P. Q. (1999). Ecological understandings of mental and physical illness. *Philosophy, Psychiatry, & Psychology*, *6*(2), 109-124. https://doi.org/ pub/1/article/28287/summary

Delaney, Y., McCarthy, J., & Beecham, S. (2017, June). Convergent parallel design mixed-methods case study in problem-based learning. In *ECRM 2017 16th European Conference on Research Methods in Business and Management* (p. 408). Academic Conferences and Publishing Limited.

Dixit, S.K., & Sambasivan, M. (2020). An integrated metatheoretical perspective of public health services delivery organizations, public, healthcare services delivery organizations. *Public Organization Review, 20* (2), 319-335. https://doi.org/10.1007/s11115-019-00440-w

Dohlman, L., DiMeglio, M., Hajj, J., & Laudanski, K. (2019). Global brain drains: How can the Maslow theory of motivation improve our understanding of physician migration? *International Journal of Environmental Research and Public Health*, *16*(7), 1182. https://doi.org/10.3390/ijerph16071182

Donald, E. (2016). Helping patients and families understand the financial impact of end-of-life care. *AJN, American Journal of Nursing*, *116*(12), 11. https://doi.org/10.1097/01.naj.0000508643.17823.b6

Drennan, A. V., & Wittenauer, M. A. (1987). Leadership behavior of nurse managers and job satisfaction of registered nurses in a hospice-home care setting: Study finds great need for strong management leadership. *American Journal of Hospice Care*, *4*(1), 28-34. https://doi.org/10.1177/104990918700400106

Duchscher, J., & Corneau, K. (2023). Nursing the future 2.0: Reimagining new graduate transition in the Covid-19 Era (Part II). *Nursing Administration Quarterly*, *47*(1), 55-63. https://doi.org/10.1097/NAQ.0000000000000561

El-Jawahri, A., LeBlanc, T.W., Kavanaugh, A., Webb, J.A., Jackson, V.A., Campbell, T.C., O'Connor, N., Luger, S.M., Gafford, E., Gustin, J., & Bhatnagar, B. (2021). Effectiveness of integrated palliative and oncology care for patients with acute myeloid leukemia: A randomized clinical trial. *JAMA Oncology*, *7*(2), 238-245. https://doi.org/10.1001/jamaoncol.2020.6343

Emery, A., & Anderman, L. H. (2020). Using interpretive phenomenological analysis to advance theory and research in educational psychology. *Educational Psychologist, 55*(4), 220231. https://doi.org/10.1080/00461520.2020.1787170

Ernst, T. (2021). Addressing spiritual needs and spiritual care from a volunteers' perspective. *Spiritual Needs in Research and Practice*, 467–471. https://doi.org/10.1007/978-3-030-70139-0_33

Esposito, C., Di Napoli, I., Agueli, B., Marino, L., Procentese, F., & Arcidiacono, C. (2022). Well-being and the covid-19 pandemic. *European Psychologist*. https://doi.org/10.1027/1016-9040/a000468

Eysenbach, G. (2004). Improving the quality of Web surveys: The Checklist for Reporting Results of Internet E-Surveys (CHERRIES). *Journal of Medical Internet Research*, *6*(3), e132. https:/doi.org/.10.2196/jmir.6.3.e34

Fisher, E. A. (2009). Motivation and leadership in social work management: A review of theories and related studies. *Administration in Social Work*, *33*(4), 347-367. https://doi.org/10.1080/036431009027691

Flick, U. (2018). Triangulation in data collection. *The SAGE handbook of qualitative data collection*, 527-544. https://methods.sagepub.com/book/the-sage-handbook-of-qualitative-data-collection/i3530.xml

Flynn, B. B., Schroeder, R. G., & Sakakibara, S. (1994). A framework for quality management research and an associated measurement instrument. *Journal of Operations Management*, *11*(4), 339-366. https://doi.org/10.1016/S0272-6963(97)90004-8

Forbes, M. K., Greene, A. L., Levin-Aspenson, H. F., Watts, A. L., Hallquist, M., Lahey, B. B., & Krueger, R. F. (2021). Three recommendations are based on comparing the reliability and validity of the predominant models used in research on the empirical structure of psychopathology. *Journal of Abnormal Psychology*, *130*(3), 297. http://doi.org/10.1037/abn0000533

Freeman, M. (2011). Validity in dialogic encounters with hermeneutic truths. *Qualitative Inquiry*, *17*, 543-551. https://doi.org/10.1177/1077800411409887

Frezza, E. E. (2019). Involvement of family members and caregivers. *Patient-Centered Healthcare*, 163–168. https://doi.org/10.4324/9780429032226-22

Friedman, B. T., Harwood, M. K., & Shields, M. (2002). Barriers and enablers to hospice referrals: An expert overview. *Journal of Palliative Medicine*, *5*(1), 73-84. https://doi.org/10.1089/10966210252785033

Funk, L. M., Allan, D. E., & Stajduhar, K. I. (2009). Palliative family caregivers' accounts of health care experiences: The importance of "security." *Palliative & Supportive Care*, *7*(4), 435-447. https://doi.org/10.1017/S1478951509990447

Funk, L., Krawczyk, M., Cherba, M., Cohen, S. R., Dujela, C., Nichols, C., & Stajduhar, K. (2023). 'The beauty and the less beautiful': Exploring the meanings of dying at 'home' among community and practitioner representatives and advocates across Canada. *Palliative Care and Social Practice*, *17*, 26323524231156944. https://doi.org/10.1177/2632352423115694

Gadke, D. L., Kratochwill, T. R., & Gettinger, M. (2021). Incorporating feasibility protocols in intervention research. *Journal of School Psychology*, *84,* 118. https://doi.org/10.1016/j.jsp.2020.11.004

Gamlen, A., & McIntyre, C. (2018). Mixing methods to explain emigration policies: A post-positivist perspective. *Journal of Mixed Methods Research*, *12*(4), 374-393. https://doi.org/10.1177/1558689818782822

Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research, 14* (10), 14291452. https:// doi.org/10.1177/1049732304270394

Geyman, J. (2018). Crisis in U.S. health care: Corporate power still blocks reform. *International Journal of Health Services*, *48*(1), 5-27. https://doi.org/10.1177/0020731417729654

Giammalva, G. R., Iacopino, D. G., Azzarello, G., Gaggiotti, C., Graziano, F., Gulì, C., & Maugeri, R. (2018). End-of-life care in high-grade glioma patients. The palliative and supportive perspective. *Brain Sciences*, *8*(7), 125. https://doi.org/2076-3425/8/7/125

Gilissen, J., Pivodic, L., Unroe, K. T., & Van den Block, L. (2020). International COVID-19 palliative care guidance for nursing homes leaves key themes unaddressed. *Journal of Pain and Symptom Management*, *60*(2), e56-e69. https://doi.org/10.1016/j.jpainsymman.2020.04.151

Gober, J. L. (2002). *Interprofessional perceptions between occupational therapists and physical therapists: barriers to effective interdisciplinary team functioning*. [Doctoral dissertation, Florida International University]. FIU Electronic Theses and Dissertations. 4002. https://doi.org/10.25148/etd.FI15101603

Gomez-Cano, M., Lyratzopoulos, G., & Abel, G. A. (2019). Patient experience drivers of overall satisfaction with care in cancer patients: Evidence from responders to the English cancer patient experience survey. *Journal of Patient Experience*, *7*(5), 758–765. https://doi.org/10.1177/2374373519889435

Gowda, V., Kwaramba, T., Hanemann, C., Garcia, J. A., & Barata, P. C. (2021). Artificial intelligence in cancer care: Legal and regulatory dimensions. *The Oncologist*, *26*(10), 807-810. https://doi.org/10.1002/onco.13862

Graven, V., & Timm, H. (2019). Hospice philosophy in practice—Toward an authentic death. *OMEGA - Journal of Death and Dying*, *83*(2), 325–342. https://doi.org/10.1177/0030222819852850

Grech, P., & Grech, R. (2021). Stroke knowledge: Developing a framework for data integration in a sequential exploratory mixed-method study. *Research Methods in Medicine & Health Sciences, 2*(2), 68-81. https://doi.org/10.1177/2632084320978040

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). Validity and reliability (credibility and dependability) in qualitative research and data analysis. *Applied Thematic Analysis, 79,* 106. https://methods.sagepub.com/book/applied-thematic-analysis/n4.xml

Guetterman, T. C., Babchuk, W. A., Howell Smith, M. C., & Stevens, J. (2019). Contemporary approaches mixed-methods–grounded theory research: A field-based analysis. *Journal of Mixed Methods Research*, *13*(2), 179-195. https://doi.org/10.1177/1558689817710877

Hakola, O. J. (2019). Advertising hospice care services. *Death Studies*, 1-9. https://doi.org/10.1080/07481187.2019.1686089

Hall, M. A. (2020). Critical care registered nurses' preparedness in the provision of end-of-life care. *Dimensions of Critical Care Nursing*, *39*(2), 116-125. https://doi.org/ 10.1097/DCC.0000000000000406\

Hancock, D. R., Algozzine, B., & Lim, J. H. (2021). *Doing case study research: A practical guide for beginning researchers* (4th ed.). Teachers College Press.

Handzo, G., Hughes, B., Bowden, J., Kelly, B., Lynch, J., Mercier, M., & Tuttle, M. (2020). Chaplaincy in the outpatient setting getting from here to there. *Journal of Health Care Chaplaincy*, 1-14. https://doi.org/10.1080/08854726.2020.1818359

Harrison, R. L., Reilly, T. M., & Creswell, J. W. (2020). Methodological rigor in mixed methods: An application in management studies. *Journal of Mixed Methods Research*, *14*(4), 473-495. https://doi.org/10 1177/1558689819900585

Haugland, V. L., & Reime, M. H. (2020). Full time or part time? Working time preferences among registered nurses. *Sykepleien Forskning*, *14*(79832). https://doi.org/10.4220/sykepleienf.2019.79832en

Haverhals, L. M., Manheim, C. E., Mor, V., Ersek, M., Kinosian, B., Lorenz, K. A., Faricy-Anderson, K. E., Gidwani-Marszowski, R. A., & Levy, C. (2018). The experience of providing hospice care concurrent with cancer treatment in the V.A. *Supportive Care in Cancer*, *27*(4), 1263–1270. https://doi.org/10.1007/s00520-018-4552-z

Hawkes, N. (2019). Mental health act: Care in wards is often unsafe and poor quality says watchdog. *BMJ*, l911. https://doi.org/10.1136/bmj.l911

Heath, S. (2021). *End of life care patient's satisfaction hinges on longer hospice care*. Retrieved September 4, 2021. https://patientengagementhit.com/news/end-of-life-patient-satisfaction-hinges-on-longer-hospice-care

Head, G. (2020). Ethics in educational research: Review boards, ethical issues, and researcher development. *European Educational Research Journal*, *19(*1), 72-83. https://doi.org/10.1177/1474904118796315

Hébert, J. R., Frongillo, E. A., Adams, S. A., Turner-McGrievy, G. M., Hurley, T. G., Miller, D. R., & Ockene, I. S. (2016). Perspective: Randomized controlled trials are not a panacea for diet-related research. *Advances in Nutrition*, *7(*3), 423-432. https://doi.org/10.3945/an.115.011023

Hennessy, N., Neenan, K., Brady, V., Sullivan, M., Eustace-Cooke, J., & Timmins, F. (2020). End of life in acute hospital setting—A systematic review of families' experience of spiritual care. *Journal of Clinical Nursing*, *29*(7-8), 1041-1052. https://doi.org/10.1111/jocn.15164

Higgins, J. P., Savović, J., Page, M. J., R. G., & Sterne, J. A. (2019). Assessing risk of bias in a randomized trial. *Cochrane Handbook for Systematic Reviews of Interventions*, 205-228. https://doi.org/10.1002/9781119536604.ch8

Hinojosa, R. (2019). Veterans' likelihood of reporting cardiovascular disease. *Journal of the American Board of Family Medicine, 32*(1), 50-57. https://doi.org/10.3122/jabfm.01180148

Hiver, P., Al-Hoorie, A. H., & Larsen-Freeman, D. (2021). Toward a transdisciplinary integration of research purposes and methods for Complex Dynamic Systems Theory: Beyond the quantitative–qualitative divide. *International Review of Applied Linguistics in Language Teaching*. https://doi.org/10.1515/iral-2021-0022/html

Holland, J. M., Keene, J. R., Kirkendall, A., & Luna, N. (2015). Family evaluation of hospice care: Examining direct and indirect associations with overall satisfaction and caregiver confidence. *Palliative & Supportive Care*, *13*(4), 901-908. https://doi.org/10.1017/S1478951514000595

Holm, M., Alvariza, A., Fürst, C. J., Wengström, Y., Årestedt, K., Öhlen, J., & Goliath, I. (2017). Recruiting participants to a randomized controlled trial testing an intervention in palliative cancer care–the perspectives of health care professionals. *European Journal of Oncology Nursing*, *31*, 6-11. https://doi.org/10.10116/j. elon2017.09.001

Hospicare, (2021). Lecture on compassionate care of life issues. Retrieved, October 05, 2021. https://hospicare.org/event/2017bemlectur

Hu, Y., Jiao, M., & Li, F. (2019). Effectiveness of spiritual care training to enhance spiritual health and spiritual care competency among oncology nurses. *BMC Palliative Care, 18* (1), 1-19. https://doi.org/10.1186/s12904-019-0489-3

Hughes, N. M., Noyes, J., Eckley, L., & Pritchard, T. (2019). What do patients and family-caregivers value from hospice care? A systematic mixed studies review. *BMC Palliative Care*, *18*(1), 1-13. https://doi.org/10.1186/s12904-019-0401

Hulme, A., Stanton, N. A., Walker, G. H., Waterson, P., & Salmon, P. M. (2021). Testing the reliability and validity of risk assessment methods in human factors and ergonomics. *Ergonomics*, 122. https://doi.org/10.1080/00140139.2021.1962969

Hunter, R. F., Gough, A., O'Kane, N., McKeown, G., Fitzpatrick, A., Walker, T., & Kee, F. (2018). Ethical issues in social media research for public health. *American Journal of Public Health*, *108*(3), 343-348. https://doi.org/10.2105/AJPH.2017.304249

Hutcheson, A. (2011). Hospice care in the United States. *Primary Care: Clinics in Offices Practice*, *38*(2), 173–182. https://doi.org/10.1016/j.pop.2011.03.002

Jacobs, L. A., & Shulman, L. N. (2017). Follow up on the care of cancer survivors: Challenges and solutions. *The Lancet Oncology*, *18*(1), e19-e29. https://doi.org/10.1016/S1470-2045(16)30386-2

Jemal, A., Culp, M. B. B., Ma, J., Islami, F., & Fedewa, S. A. (2020). Prostate cancer incidence 5 years after U.S. preventive services task force recommendations against screening. *Journal of the National Cancer Institute*, *113*(1), 64–71. https://doi.org/10.1093/jnci/djaa068

Jensen, S. 2017). *Social media usage: The impact on feeling of depression or loneliness.* Skidmore College. https://doi.org/10.31235/osf.io/j3azw

Jha, D., Frye, A. K., & Schlimgen, J. (2017). Evaluating variables of patient experience and the correlation with design. *Patient Experience Journal*, *4*(1), 33-45. https://doi.org/10.35680/2372-0247.1176.

Jin, Y., Misra, S., Homan, D., & Rasmus, J. (2020). Effects of wettability of conductive particles on the multifrequency conductivity and permittivity of fluid-filled porous material. *Fuel*, *268*, 117411. https://doi.org/10.1016/j.fuel.2020.117411

Jo, M., Na, H., & Jung, Y. E. (2020). Mediation effects of compassion satisfaction and compassion fatigue in the relationships between resilience and anxiety or depression among hospice volunteers. *Journal of Hospice & Palliative Nursing*, *22*(3), 246-253. https://doi.org/10.1097/NJH.0000000000000640

Johnson, R. B. & Onwuegbuzie, A. J. (2004). Mixed-methods research: a research paradigm whose time has come. *Educational Researcher*, *33(*7), 14-26. https://doi.org/10.3102/0013189X033007014

Johnson, R. B., Russo, F., & Schoonenboom, J. (2019). Causation in mixed methods research: The meeting of philosophy, science, and practice. *Journal of Mixed Methods Research*, *13*(2), 143-162. https://doi.org/10.1177/1558689817719610

Johnston, E. E., Martinez, I., Currie, E., Brock, K. E., & Wolfe, J. (2020). Hospital or home? Where should children die and how do we make that a reality? *Journal of Pain and Symptom Management*, *60*(1), 106- 155. https://doi.org/10.1016/j.jpainsymman.2019.12.370

Jose, N., Chakravarthi, B. R., Suryawanshi, S., Sherly, E., & McCrae, J. P. (2020, March). A survey of current datasets for code-switching research. In *2020 6th International Conference on Advanced Computing and Communication Systems (ICACCS)* (pp. 136-141). IEEE. https://ieeexplore.ieee.org/abstract/document/9074205\

Jung, C., Hunter, A., Saleh, M., Quinn, G. P., & Nippita, S. (2023). Breaking the binary: How clinicians can ensure everyone receives high quality reproductive health services. *Open Access Journal of Contraception*, 23-39. https://doi.org/ 10.2147/OAJC.S368621

Kalpande, S. D., & Toke, L. K. (2023). Reliability analysis and hypothesis testing of critical success factors of total productive maintenance. *International Journal of Quality & Reliability Management*, *40*(1), 238-266. https://doi.org/10.1108/IJQRM-03-2021-0068

Kästner, D., Weigel, A., Buchholz, I., Voderholzer, U., Löwe, B., & Gumz, A. (2021). Facilitators and barriers in anorexia nervosa treatment initiation: A qualitative study on the perspectives of patients, careers, and professionals. *Journal of Eating Disorders*, *9*(1), 111. https://doi.org/10.1186/s40337-021-00381-0

Kerin, R. & Hartley, S. (2019). *Marketing* [VitalSource Bookshelf]. Retrieved from https://online.vitalsource.com/#/books/1260809773

Khare, S. R., Batist, G., & Bartlett, G. (2016). Identification of performance indicators across a network of clinical cancer programs. *Current Oncology*, *23*(2), 81-90. https://doi.org/10.3747/co.23.2789

Kim, K. N., Qureshi, M. M., Huang, D., Ko, N. Y., Cassidy, M., Oshry, L., & Hirsch, A. E. (2020). The impact of locoregional treatment on survival in patients with metastatic breast cancer: A National Cancer Database Analysis. *Clinical Breast Cancer*, *20*(2). https://doi.org/10.1016/j.clbc.2019.12.010

Kitzes, J. A., & Anderson, R. P. (2003). *Hospice and palliative care: Concepts and practice*. Jones & Bartlett Learning.

Kleinman, A. (2017). The illness narratives. *Academic Medicine*, *92*(10), 1406. https://doi.org/10.1097/acm.0000000000001864

Kluge, A., Schüffler, A. S., Thim, C., Haase, J., & Gronau, N. (2019). Investigating unlearning and forgetting in organizations. *The Learning Organization*, *26*(5), 518–533. https://doi.org/10.1108/tlo-09-2018-0146

Koch, K. D., & Jones, B. L. (2018). Supporting parent caregivers of children with life-limiting illness. *Children*, *5*(7), 85. https://doi.org/10.3390/children5070085

Kogan, A. C., Rahman, A., Lomeli, S., & Enguidanos, S. (2023). "You cannot stop talking about palliative care:" Perspectives and learnings from providers on communicating about home-based palliative care to patients and physicians. *American Journal of Hospice and Palliative Medicine*, *40*(2), 122-128. https://doi.org/10.1177/10499091221109049

Komatsu, H., & Komatsu, Y. (2023). The role of nurses on the treatment decision support for older people with cancer: A systematic review. *Healthcare*, *11*(4), 546. MDPI. https://doi.org/10.3390/healthcare11040546

Krauss, S. E. (2005). Research paradigms and meaning making: A primer. *The Qualitative Report*, *10(4)*, 758-770. Retrieved, from htttp://www.nova.edu.sss/or/or10-4/krauss.pdf

Krisman-Scott, M. A. (2003). Origins of hospice in the United States. *Journal of Hospice & Palliative Nursing*, *5*(4), 205–210. https://doi.org/10.1097/00129191-200310000-00014

Kweku Sey, A., & Hunter, J. (2020). Finding the value in oncology massage: A mixed-method study of cancer services and survivors in Australia. *Advances in Integrative Medicine*, *7*(3), 126–134. https://doi.org/10.1016/j.aimed.2020.01.003

Kyngäs, H., Kääriäinen, M., & Elo, S. (2020). The trustworthiness of content analysis. In *The application of content analysis in nursing science research* (pp. 4148). Springer. https://doi.org/10.1007/978-3-030-30199-6_5

Lacasa-Gomar, J. (1970). *The sender-linker-receiver communication model*. Iowa State. https://doi.org/10.31274/rtd-180817-2012

Lacerenza, C. N., Marlow, S. L., Tannenbaum, S. I., & Salas, E. (2018). Team development interventions: Evidence-based approaches for improving teamwork. *American Psychologist, 73*(4), 517–531. https://doi.org/10.1037/amp0000295

Lagman, R. A., Yoo, G. J., Levine, E. G., Donnell, K. A., & Lim, H. R. (2014). “Leaving it to God” religion and spirituality among Filipina immigrant breast cancer survivors. *Journal of Religion and Health*, *53*(2), 449-460. https://doi.org/10.1007/s10943012-9648-z

Lam, K. K., & Hung, S. Y. (2019). Compassion fatigue among healthcare personnel in acute care contexts: An integrative review. *Journal of Nursing and Health Care (JNHC), 4*(1). https://doi.org/10.5176/2345-7198_4.1.114

Laabar, T. D., Auret, K., Saunders, C., Ngo, H., & Johnson, C. E. (2022). Support needs for Bhutanese family members taking care of loved ones diagnosed with advanced illness. *Journal of Palliative Care*, *37*(3), 401-409. https://doi.org/10.1177/08258597211066248

Laranjeira, C., & Dourado, M. (2022). "Dignity as a small candle flame that doesn't go out!": An interpretative phenomenological study with patients living with advanced chronic obstructive pulmonary disease. *International Journal of Environmental Research and Public Health*, *19*(24), 17029. https://doi.org/10.3390/ijerph192417029

Lattanzi-Licht, M., & Connor, S. (2018). Care of the dying: The hospice approach. In *Dying: Facing the facts* (pp. 143-162). Taylor & Francis. https://www.taylorfrancis.com/chapters/edit/10.4324/9781315800806-6/care-dying-hospice-approach-marcia-lattanzi-licht-stephen-connor

Latting, J. K. (1991). Eight myths on motivating social services workers: Theory-based perspectives. *Administration in Social Work*, *15*(3), 49-66. https://doi.org/10.1300/J147v15n03_04

Lawler, J., Leary, A., Lofton, L., & Bushe, D. (2020). Perceptions of the cancer care left undone in primary and community services: A mixed-methods evaluation. *Health & Social Care in the Community*, *28*(6), 2117–2124. https://doi.org/10.1111/hsc.13022

Leadership Theories. (2021). *What are leadership theories*? Corporate Finance Institute. Retrieved 4 September 2021, from https://corporatefinanceinstitute.com/resources/careers/soft-skills/leadership-theories/

Lee, G. L., & Ramaswamy, A. (2018). Physical, psychological, social, and spiritual aspects of end-of-life trajectory among patients with advanced cancer: A phenomenological inquiry. *Death Studies*, *44*(5), 292–302. https://doi.org/10.1080/07481187.2018.1541944

Leedy, P. D., & Ormrod, J. E. (2021). *Practical research: Planning and design*. Pearson Education Limited. https://www.pearsonhighered.com/assets/preface/0/1/3/4/0134775651.pdf\

Levitt, H. M., Motulsky, S. L., Wertz, F. J., Morrow, S. L., & Ponterotto, J. G. (2017). Recommendations for designing and reviewing qualitative research in psychology: Promoting methodological integrity. *Qualitative Psychology, 4(*1), 2. https://doi.org/10.1037/qup0000082

Li, S. A., Jeffs, L., Barwick, M., & Stevens, B. (2018). Organizational contextual features that influence the implementation of evidence-based practices across healthcare settings: A systematic integrative review. *Systematic Reviews, 7(*1), 119. https://doi.org/10.1186/s13643018-0734-5

Longenecker, P. D. (2006). Evaluating transformational leadership skills of hospice executives. *American Journal of Hospice and Palliative Medicine*, *23*(3), 205-211. https://doi.org/10.1177/1049909106289082

Love, H. R., & Corr, C. (2021). Integrating without quantitating: Two examples of deductive analysis strategies within qualitatively driven mixed methods research. *Journal of Mixed Methods Research*, *16(*1), 64-87. https://doi.org/10.1177/1558689821989833

Łukowski, W. (2017). The impact of leadership styles on innovation management. *Marketing of Scientific and Research Organizations*, *24*(2), 105-136. https://doi.org/10.14611/minib.24.06.2017.12

Lupu, D., Quigley, L., Mehfoud, N., & Salsberg, E. S. (2018). The growing demand for hospice and palliative medicine physicians: Will the supply keep up? *Journal of Pain and*

Symptom Management, *55*(4), 1216–1223. https://doi.org/10.1016/j.jpainsymman.2018.01.011

Lussier, K. (2019). Motives, managers, and Maslow: The hierarchy of needs in American management, 1960-1985. *Academy of Management Proceedings, 2019*(1), 17655. https://doi.org/10.5465/ambpp.2019.202

Maggio, L. A., Krakow, M., & Moorhead, L. L. (2020). 'There were some clues': A qualitative study of heuristics used by parents of adolescents to make credibility judgements of online health news articles citing research. *BMJ Open*, *10*(8), e039692. https://doi.org/10.1136/bmjopen-2020-039692

Mahapatra, S., Nayak, S., & Pati, S. (2016). Quality within care in cancer: An exploration of the patient perspectives. *Journal of Family Med and Primary Care*, *5*(2), 338–342. https://doi.org/10.4103/2249-4863.192349

Manzoor, A. (2020). Designs of mixed method research. In *Cognitive analytics: Concepts, methodologies, tools, and applications* (pp. 95-121). IGI Global. https://doi.org/10.4018/978-1-7998-2460-2.ch007

Marzal-Alfaro, M., Rodriguez-Gonzalez, C. G., Escudero-Vilaplana, V., Revuelta-Herrero, J. L., González-Haba, E., Ibáñez-Garcia, S., Iglesias-Peinado, I., Herranz-Alonso, A., & Sanjurjo Saez, M. (2020). Risks and medication errors analysis to evaluate the impact of a chemotherapy compounding workflow management system on cancer patients' safety. *Health Informatics Journal*, *26*(3), 1995–2010. https://doi.org/10.1177/146045821895434

Mathews, J., Hannon, B., & Zimmermann, C. (2021). Models of integration of specialized palliative care with oncology. *Current Treatment Options in Oncology*, *22*(5), 18. https://doi.org/10.1007/s11864-021-00836-1

Mayoh, J., & Onwuegbuzie, A. J. (2015). Toward a conceptualization of mixed methods phenomenological research. *Journal of Mixed Methods Research*, *9*(1), 91-107. https://doi.org/10.1177/1558689813505358

McCusker, K., & Gunaydin, S. (2014). Research using qualitative, quantitative, or mixed methods and choice based on the research. *Perfusion*, *30*(7), 537–542. https://doi.org/10.1177/0267659114559116

McGregor, D. E., Palarea-Albaladejo, J., Dall, P. M., Hron, K., & Chastin, S. F. M. (2020). Cox regression survival analysis with compositional covariates: Application to modeling mortality risk from 24-h physical activity patterns. *Statistical Methods in Medical Research*, *29(*5), 14471465. https://doi.org/10.1177/0962280219864125

McGregor, S. L. (2017). *Understanding and evaluating research: A critical guide*. Sage Publications.

McRae, S. L. (2017). Transforming leadership for patient satisfaction. *Nursing Management*, *48*(2), 51–54. https://doi.org/10.1097/01.numa.0000511923.13387.69

Measuring the Quality of Hospice Care, (2016). Agency for Healthcare Research and Quality. Rockville, MD. https://www.ahrq.gov/talkingquality/measures/setting/long-term-care/hospice.html

Meier, D. (2010). Mental health. Health and wellness for life. https://doi.org/10.5040/9781718209251.ch-005

Mele, V., & Belardinelli, P. (2019). Mixed methods in public administration research: Selecting, sequencing, and connecting. *Journal of Public Administration Research and Theory*, *29*(2), 334347. https://doi.org/10.1093/jopart/muy046

Meltzer, R., & Schwartz, A. (2018). Introduction. *Policy analysis as problem-solving*, 1–14. Routledge. https://doi.org/10.4324/9781315209678-1

Methuen, C. (2017). "The Bible is the word of God. So, what does it tell us about war?" *Journal of the Bible and Its Reception*, *4*(2). https://doi.org/10.1515/jbr-2017-0003

Miller, K. D., Fidler-Benaoudia, M., Keegan, T. H., Hipp, H. S., Jemal, A., & Siegel, R. L. (2020). Cancer statistics for adolescents and young adults, 2020. *CA: A Cancer Journal for Clinicians, 70*(6), 443-459. https://doi.org/10.3322/caac.21637

Miracle, V. A. (2016). The Belmont Report: The triple crown of research ethics. *Dimensions of Critical Care Nursing, 35(*4), 223-228. https:// doi.org/10.1097/DCC.0000000000000018

Mohajan, H. K. (2017). Two criteria for good measurements in research: Validity and reliability. *Annals of Spiru Haret University*: *Economic Series, 17(*4), 59-82. https://www.ceeol.com/search/article-detail?id=673569

Mohiuddin, A. K. (2020). *The pharmacist's role in patient care: Achieving high quality, cost-effective and accessible healthcare through a team-based, patient-centered approach*. Universal-Publishers.

Molina-Mula, J., & Gallo-Estrada, J. (2020). Impact of nurse-patient relationship on quality of care and patient autonomy in decision-making. *International Journal of Environmental Research and Public Health*, *17*(3), 835. https://doi/org/10.3390/ijerph17030835

Mollica, M. A., Lines, L. M., Halpern, M. T., Ramirez, E., Schussler, N., Urato, M., Wilder Smith, A., & Kent, E. E. (2017). Patient experiences of cancer care: scoping review, future directions, and introduction of a new data resource: Surveillance epidemiology and end results-consumer assessment of healthcare providers and systems (Seer-Cahps). *Patient Experience Journal*, *4*(1), 103–121. https://doi.org/10.35680/2372-0247.1167

Montes-Galdeano, F., Roman, P., Ropero-Padilla, C., Romero-López, A., Ruiz-González, C., & Rodriguez-Arrastia, M. (2021). Improving the care management of trans patients: Focus groups of nursing students' perceptions. *Journal of Nursing Management, 29*(1), 75-84. https://doi.org/10.1111/jonm.13160

Moore, E., (2021). Doctor of business administration., V(2),1-67, DBA Dissertation Guide. https://canvas.liberty.edu/courses/162123/assignments/2183932

Morita, T., Imai, K., Yokomichi, N., Mori, M., Kizawa, Y., & Tsuneto, S. (2017). Continuous deep sedation: a proposal for performing more rigorous empirical research. *Journal of Pain and Symptom Management*, *53*(1), 146-152. https://www.doi.org/pii/S0885392416303621

Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research*, *5*(2), 147-149. https://doi.org/10.1177/104973239500500201

Morse, J. M. (2012). The implications of interview type and structure in mixed-method designs. *The SAGE handbook of interview research: The complexity of the craft*, 193-204. https://books.google.com/books?hl=en&lr=&id=_hp1AwAAQBAJ&oi=fnd&pg=PA193&dq=Morse,+J.+M.+(2012).+The+implications+of+interview+type+and+structure+in+mixed-method+designs.+The+SAGE+handbook+of+interview+research:+The+complexity+of+t

he+craft,+193¬204.+&ots=tXSeiQFl0l&sig=v9mElTs2QYet-eXnAg7T1L5so1c#v=onepage&q&f=false

Mosadeghrad, A. M. (2012). A conceptual framework for quality of care. *Materia Socio-Medica*, *24*(4), 251. https://doi.org/10.5455/msm.2012.24.251-261

Moudi, A., Iravani, M., Najafian, M., Zareiyan, A., Forouzan, A., & Mirghafourvand, M. (2020). The development and validation of an obstetric triage acuity index: A mixed-method study. *The Journal of Maternal-Fetal & Neonatal Medicine*, 111. https://doi.org/10.1080/14767058.2020.1768239

Muhaimin, M., Habibi, A., Mukminin, A., Saudagar, F., Pratama, R., Wahyuni, S. & Indrayana, B. (2019). A sequential explanatory investigation of tpack: Indonesian science teachers' survey and perspective. *Journal of Technology and Science Education*, 9(3), 269-281. https://doi.org/10.3926/jotse.662

Munafò, M. R., Tilling, K., Taylor, A. E., Evans, D. M., & Davey Smith, G. (2018). Collider scope: When selection bias can substantially influence observed associations. *International Journal of Epidemiology*, *47(*1), 226-227. https://doi.org/10.1093/ije/dyx206

Murray, T. G., & Thompson, J. T. (2021). Do health care institutions deliver retina care at a loss? *Ophthalmology Retina*, *5*(6), 493-495. https://doi.org/10.1016/j.oret.2021.03.015

Mutebi, M., Anderson, B. O., Duggan, C., Adebamowo, C., Agarwal, G., Ali, Z., & Eniu, A. (2020). Breast cancer treatment: A phased approach to implementation. *Cancer, 126,* 2365–2378. https://dio.org/10.1002/cncr.32910

Mysore, M. R., & Ranjit, S. (2023). Organizing and leading a multidisciplinary PICU. *Indian Journal of Pediatrics*, 1-10. https://doi.org/10.1007/s12098-022-04427-2

Nagata, C., Tsutsumi, M., Kiyonaga, A., & Nogaki, H. (2021). Evaluation of a training program for community-based end-of-life care of older people toward aging in place: A mixed-methods study. *Nurse Education in Practice*, *54*, 103091. https://doi.org/10.1016/j.nepr.2021.103091

Nalley, C. (2021). Addressing disparities in hospice & palliative care. *Oncology Times*, *43*(6). https://doi.org/10.1097/01.cot.0000741732.73529.bb

Newman, E. J., & Schwarz, N. (2018). Good sound, good research: How audio quality influences perceptions of the research and researcher. *Science Communication*, *40*(2), 246- 257. https://doi.org/10.1177/1075547018759345

NHPCO Facts and Figures, (2020). *Hospice care in America.* Alexandria, VA: National Hospice and Palliative Care Organization. https://www.wicz.com/story/42504991/nhpco-releases-new-facts-and-figures-report-on-hospice-care-in-america

Noltemeyer, A., James, A. G., Bush, K., Bergen, D., Barrios, V., & Patton, J. (2021). The relationship between deficiency needs and growth needs: The continuing investigation of Maslow’s theory. *Child & Youth Services*, *42*(1), 24-42. https://dio.org/10.1080/0145935X.2020.1818558

Obasun, F. (2020). The human corona-virus circulation in the USA, 2019-2020. *Journal of Public Health Research and Metrics*, *1*(1), 1-3. https:// doi:10.5281/zenodo.3735345

Odejide, O. O., & Steensma, D. P. (2020). Patients with hematological malignancies should not have to choose between transfusions and hospice care. *The Lancet Hematology*, *7*(5), e418-e424. https://doi.org/10.1016/S2352-3026(20)30042-9

Office for Human Research Protections. (2021). Regulations, policy & guidance. https://www.hhs.gov/ohrp/regulations-and-policy/index.html

Oliver, A., Galiana, L., Simone, G. D., Tomás, J. M., Arena, F., Linzitto, J., Gladys, G., & Sansó, N. (2021). Palliative care professionals' inner lives: Cross-cultural application of the awareness model of self-care. *Healthcare*, *9*(1), 81. http://dx.doi.org/10.3390/healthcare9010081

Onwuegbuzie, A. J., & Collins, K. M. (2007). A typology of mixed methods sampling designs in social science research. *The Qualitative Report*, *12*(2), 281-316. https://doi.org/10.46743/2160-3715/2007.1638

Onwuegbuzie, A. J., Frels, R. K., Leech, N. L., & Collins, K. M. T. (2011). A mixed research study of pedagogical approaches and student learning in doctoral-level mixed research courses. [Special issue]. *International Journal of Multiple Research Approaches, 5*, 169-202. https://doi.org/10.5172/mra.2011.5.2.169

Onwuegbuzie, A. J., & Johnson, R. B. (2006). The validity issue in mixed research. *Research in the Schools*, *1*(1), 48-63. The Routledge Reviewer's Guide to Mixed Methods Analysis GoogleBooks.https://www.lcwu.edu.pk/ocd/cfiles/Gender%20&%20Development%20Studies/GDS-502/Thevalidityissueinmixedresearch.pdf#page=55

Onwuegbuzie, A. J., & Johnson, R. B. (2021). Mapping the emerging landscape of mixed analysis. *The Routledge reviewer's guide to mixed methods analysis*, 122. The Routledge Reviewer's Guide to Mixed Methods Analysis - Google Books

Onwuegbuzie, A. J., Wilcox, R., Gonzales, V., Hoisington, S., Lambert, J., Jordan, J., Aleisa, M., Benge, C. L., Wachsmann, M. S., & Valle, R. (2018). Collaboration patterns among mixed Researcher: A multidisciplinary examination. *International Journal of Multiple Research Approaches, 10,* 437-457. https://doi.org/10.29034/ijmra. v10n1a3

Oriani, A., Fusi-Schmidhauser, T., & Guo, P. (2021). Should end-of-life patients be enrolled as participants in clinical research? A best-fit framework synthesis. *Journal of Advanced Nursing*, *77*(4), 1656-1666. https://doi.org/10.1111/jan.14712

Osagiede, O., Colibaseanu, D. T., Spaulding, A. C., Frank, R. D., Merchea, A., Kelley, S. R., Uitti R. J., & Ailawadhi, S. (2018). Palliative care employment among patients with solid cancer tumors: National Cancer Data Base study. *Journal of Palliative Care*, *33*(3), 149-158. https://doi.org/10.1177/0825859718777320

Osieja, H. (2016). *Academic freedom: Foundation, limitations, and delimitations*. Edulearn16 Proceedings. https://doi.org/10.21125/edulearn.2016.0393

Paal, P., Helo, Y., & Frick E. (2017). Spiritual care training provided to healthcare professionals: A systematic review. *Journal of Pastoral Care & Counseling*, *69(*1), 19. https://doi.org/10.1177/1542305015572955

Pandey, P., & Pandey, M. M. (2021). *Research methodology tools and techniques*. Bridge Center. http://dspace.vnbrims.org:13000/jspui/bitstream/123456789/4666/1/RESEARCH%20METHODOLOGY%20TOOLS%20AND%20TECHNIQUES.pdf

Partnership To Fight Chronic Disease, (2021). The growing crisis of chronic disease in the United States. Retrieved on October 12, 2021, from https://commed.vcu.edu/Chronic_Disease/2008/ChronicDiseaseFactSheet.pdf

Patel, M. I., Periyakoil, V. S., Moore, D., Nevedal, A., & Coker, T. R. (2018). Delivering end-of-life cancer care: perspectives of providers. *American Journal of Hospice and Palliative Medicine*, *35*(3), 497-504. https://doi.org/10.1177%2F1049909117719879

Pati, T., & Mahapatra, S. (2017). Lactational amenorrhea method. *Contraception: Past, present, and future*, https://doi.org/10.5005/jp/books/12894_9

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice*. Sage Publications.

Pesut, B., Duggleby, W., Warner, G., Bruce, P., Ghosh, S., Holroyd-Leduc, J., Nekolaichuk, C., & Parmar, J. (2020). A mixed-method evaluation of a volunteer navigation intervention for older persons living with chronic illness (Nav-Care): Findings from a knowledge translation study. *BMC Palliative Care*, *19*(1). https://doi.org/10.1186/s12904-020006662

Pavelková, H., & Bužgová, R. (2015). Burnout among healthcare workers in hospice care. *Central European Journal of Nursing and Midwifery*, *6*(1), 218-223. http://dx.doi.org/10.15452/CEJNM.2015.06.0006

Pentaris, P., & Thomsen, L. L. (2018). Cultural and religious diversity in hospice and palliative care: A qualitative cross-country comparative analysis of the challenges of healthcare professionals. *OMEGA - Journal of Death and Dying*, *81*(4), 648–669. https://doi.org/10.1177/0030222818795282

Perumalswami, C., Harris, J., & Griggs, J. (2020). High-quality care in hospice? Medical director perspectives on caring for patients with obesity in the United States (GP780). *Journal of Pain and Symptom Management*, *60*(1), 292-293. https://doi.org/10.1515/jbr-2017-003

Pesut, B., Duggleby, W., Warner, G., Bruce, P., Ghosh, S., Holroyd-Leduc, J., Nekolaichuk, C., & Parmar, J. (2020). A mixed-method evaluation of a volunteer navigation intervention for older persons living with chronic illness (Nav-Care): Findings from a knowledge translation study. *BMC Palliative Care*, *19*(1). https://doi.org/10.1186/s12904-020006662

Peter, K. A., Schols, J. M., Halfens, R. J., & Hahn, S. (2020). Investigating work-related stress among health professionals at different hierarchical levels: A cross-sectional study. *Nursing Open*, *7*(4), 969-979. https://doi.org/10.1002/nop2.469

Pratt, M. G. (2009). From the editors: For the lack of a boilerplate: Tips on writing up (and reviewing) qualitative research. *Academy of Management Journal*, *52*(5). https://doi.org/10.5465/amj.2009.44632557

Pullen, E., Fischer, M. W., Morse, G., Garabrant, J., Salyers, M. P., & Rollins, A. L. (2023). Racial disparities in the workplace: The impact of isolation on perceived organizational support and job satisfaction. *Psychiatric Rehabilitation Journal*, *46*(1), 45. https://doi.org/10.1037/prj0000543

Qutoshi, S. B. (2018). Phenomenology: A philosophy and method of inquiry. *Journal of Education and Educational Development*, *5*(1). https://doi.org/10.22555/JOEED.V5I1.2154

Raposo, S., Hogan, C. L., Barnes, J. T., Chemudupati, T., & Carstensen, L. L. (2021). Leveraging goals to incentivize healthful behaviors across adulthood. *Psychology and Aging*, *36*(1), 57. https://doi.org/10.1037/pag0000428

Raghupathi, W., & Raghupathi, V. (2018). An empirical study of chronic diseases in the United States: A visual analytics approach to public health. *International Journal of Environmental Research and Public Health*, *15*(3), 431. https://doi.org/10.3390/ijerph15030431

Ratan, S., Anand, T., & Ratan, J. (2019). Formulation of research question – Stepwise approach. *Journal of Indian Association of Pediatric Surgeons*, *24*(1), 15. https://doi.org/10.4103/jiaps.jiaps_76_18

Ray, M. A. (1985). A philosophical method to study nursing phenomena. *Qualitative Research Methods in Nursing*, 81-92. https://www.taylorfrancis.com/chapters/edit/10.4324/9780203409527-28

Reggio, C., Mowbray, C., Waldron, M. K., Rood, A. L., Sibilia, G., Mooney-Doyle, K., & Hinds, P. S. (2021). “It can be hard, but it's not bad": Three questions to solicit caregiver perceptions of benefits and burdens to participating in pediatric palliative care research. *Journal of Palliative Medicine*. https://doi.org/10.1089/jpm.2020.0618

Research Institution. (2021). The Nation’s best innovation collective minds. http://researchinstitution.org

Rhoads, C. J., Bankston, G., Roach, J., Jahnke, R., & Roth, W. (2014). Telehealth in rural Pennsylvania. *The Center for Rural Pennsylvania,* 1-128. https://www.rural.pa.gov/publications/research-reports.cfm\

Robson, C. & McCartan, K. (2016). *Real-world research* (4th ed.). John Wiley & Sons. https://scholar.google.com/citations?user=YIKKZ_YAAAAJ&hl=en&oi=sra

Romm, N. R., Romm, & Otten. (2018). *Responsible research practice*. Springer International Publishing.

Roseveare, J. (2017). A Practitioner's viewpoint: Limitations and assumptions implicit in assessment. *Psychometric Testing*, 251–261. https://doi.org/10.1002/9781119183020.ch18

Richards, N., & Krawczyk, M. (2021). What is the cultural value of dying in an era of assisted dying? *Medical Humanities*, *47*(1), 61-67. http://dx.doi.org/10.1136/medhum-2018-011621

Sackett, D. L. (1997). Evidence-based medicine. In *Seminars in perinatology* (Vol. 21, No. 1, pp. 3-5). WB Saunders. https://doi.org/10.1016/S0146-0005(97)80013-4

Sandgren, A., Axelsson, L., Bylund-Grenklo, T., & Benzein, E. (2021). Family members' expressions of dignity in palliative care: A qualitative study. *Scandinavian Journal of Caring Sciences*, *35*(3), 937-944. https://doi.org/10.1111/scs.12913

Sandsdalen, T., Grøndahl, V. A., Hov, R., Høye, S., Rystedt, I., & Wilde-Larsson, B. (2016). Patients' perceptions of palliative care quality in hospice inpatient care, hospice daycare, palliative units in nursing homes, and home care: A cross-sectional study. *BMC Palliative Care*, *15*(1), 1-18. https://doi.10.1186/s12904-016-0152-1

Saunders, M. N., & Townsend, K. (2016). Reporting and justifying the number of interview participants in organization and workplace research. *British Journal of Management*, *27*(4), 836-852. https://doi.org/10.1111/1467-8551.12182

Savović, J., Turner, R. M., Mawdsley, D., Jones, H. E., Beynon, R., Higgins, J. P., & Sterne, J. A. (2018). Association between risk-of-bias assessments and results of randomized trials in Cochrane reviews the ROBES meta-epidemiologic study. *American Journal of Epidemiology*, *187*(5), 1113-1122. https://doi.org/187/5/1113/4604571

Sawhney, N., Graver, C., & Breitkopf, E. (2018). Audio journaling for self-reflection and assessment among teens in participatory media programs. In *Proceedings of the 17th ACM Conference on Interaction Design and Children* (pp. 93-105). https://doi.org/10.1145/3202185.320275

Schoonenboom, J., & Johnson, R. B. (2017, July 5). *How to construct a mixed methods research design*. KZfSS Kölner Zeitschrift für Soziologie und Sozialpsychologie. https://doi/org/10.1007/s11577-017-0454-1

Selman, L. E., Brighton, L. J., Sinclair, S., Karvinen, I., Egan, R., Speck, P., & In Spirit Collaborative. (2018). Patients' and caregivers' needs, experiences, preferences, and research priorities in spiritual care: A focus group study across nine countries. *Palliative Medicine*, *32*(1), 216-230. https://doi.org/10.1177/0269216317734954

Setia M.S. (2016). Methodology series module 3: Cross-sectional Studies. *Indian Journal of Dermatology*, *61*(3), 261–264. https://doi.org/10.4103/0019-5154.182410

Seton, D., & Lamkin, R. (Eds.). (2020). *Hospice and palliative medicine, an issue of physician assistant clinics, E-Book* (Vol. 5, No. 3). Elsevier Health Sciences.

Shahid, N., Rappon, T., & Berta, W. (2019). Applications of artificial neural networks in health care organizational decision-making: A scoping review. *PloS One*, *14*(2), e0212356. https://doi.org/10..1371/journal.pone.0212356

Shen, J., Ma, X., Mansberger, N., Bierlein Palmer, L., Burt, W., Leneway, R., Reeves, P., Poppink, S., McCrumb, D., Whitten, E., & Gao, X., (2021). Developing and validating an instrument measuring school renewal: Testing the factorial validity and reliability. *International Journal of Leadership in Education*, 119. https://doi.org/10.1080/13603124.2021.1930187

Shi, L., & Singh. D.A. (2019). *Essentials of the U.S. health care system.* Jones and Bartlett Publishers.

Siegel, R. L., Miller, K. D., & Jemal, A. (2020). Cancer statistics. *CA: A Cancer Journal for Clinicians*, *70*(1), 7-30. https://doi.org/10.3322/caac.21590

Sileyew, K. J. (2019). Research design and methodology. In E. Abu-Taieh, A. E. Mouatasim, & I. H. A. Hadid (Eds.), *Cyberspace*. IntechOpen. https://doi.org/10.5772/intechopen.85731

Simões, A. L. (2020). Thoughts toward palliative care nurses in times of pandemic. *Patient Experience Journal*, 7(2), 27–30. https://doi.org/10.35680/2372-0247.1464Singer, P.M., & Willison, C.E. (2021). *The populist radical right and health* (M. Falkenbach, & S. L. Greer, Eds.). Springer, Cham. https://doi.org/10.1007/978-3-030-70709-5_9

Singh, J., Sillerud, B., & Omar, M. (2019a). Quality improvement in hospice settings: Perceptions of leaders. *International Journal of Health Care Quality Assurance, 32*(7), 1098-1112. https://doi.org/10.1108/IJHCQA-04-2019-0084

Singh, S. K., Gupta, S., Busso, D., & Kamboj, S. (2019b). Top management knowledge value, knowledge sharing practices, open innovation, and organizational performance. *Journal of Business Research*. https://doi.org/10.1016/j.jbusres.2019.04.040

Slater, M. (2020). Revolving doors of hospitalization and incarceration: How perceptions of procedural justice affect treatment outcomes. *Wm. & Mary J. Race Gender & Soc. Just.*, *27*, 261. https://heinonline.org/HOL/LandingPage?handle=hein.journals/wmjwl27&div=14&id=&page

Smith, B. R., Conger, M. J., McMullen, J. S., & Neubert, M. J. (2019). Why believe? The promise of research on the role of religion in entrepreneurial action. *Journal of Business Venturing Insights*, *11*, e00119. https://www.doi.org/pii/S2352673418301653

Sobanski, P. Z., Alt-Epping, B., Currow, D. C., Goodlin, S. J., Grodzicki, T., Hogg, K., & Larkin, P. J. (2020). Palliative care for people living with heart failure: European association for palliative care task force expert position statement. *Cardiovascular Research*, *116*(1), 12-27. https://doi.org/10.1093/cvr/cvz200

Solverson, K. J., des Ordons, A. L. R., & Doig, C. J. (2018). Withholding and withdrawing life support: Difficult decisions around care at the end of life. *Canadian Journal of Anesthesia/Journal canadien d'anesthésie*, *65*(1), 913. https://doi.org/10.1007/s12630-017-1001-2

Steensma, T. D., Wensing-Kruger, S. A., & Klink, D. T. (2017). How should physicians help gender transitioning adolescents consider potential iatrogenic harms of hormone therapy? *AMA Journal of Ethics*,*19*(8), 762–770. https://doi.org/10.1001/journalofethics.2017.19.8.ecas3-1708

Stevenson, D., & Sinclair, N. (2018). Complaints about hospice care in the United States, 2005–2015. *Journal of Palliative Medicine*, *21*(11), 1580-1587. https://doi.org/10.1089/jpm.2018.0125

Sy, T. (2010). What do you think of followers? Examining the content, structure, and consequences of implicit followership theories. *Organizational Behavior and Human Decision Processes*, *113*(2), 73-84. https://doi.org/10.1016/j.obhdp.2010.06.001

Tabuena, A. C., & Hilario, Y. M. C. (2021). Research data analysis methods in addressing the K12 learning competency on data analysis procedures among senior high school research courses. *International Journal of Recent Research and Applied Studies*, *8*(3), 1. http://dx.doi.org/10.2139/ssrn.3795969

Tanco, K., & Epner, D. (2018). Challenging conversations in palliative care. *Hospice and Palliative Medicine and Supportive Care Flashcards*. https://doi.org/10.1093/med/9780190633066.003.0028

Tandon, P., Walling, A., Patton, H., & Taddei, T. (2021). AGA clinical practice update on palliative care management in cirrhosis: Expert review. *Clinical Gastroenterology and Hepatology*, *19*(4). https://doi.org/10.1016/j.cgh.2020.11.027

Tan, T. K. (2022). Practical t-test power analysis with r. *Practical Assessment, Research, and Evaluation*, *27*(1), 18. https://doi.org/10.7275/mmna-sh25

Tarazi, W. W., Bradley, C. J., Harless, D. W., Bear, H. D., & Sabik, L. M. (2016). Medicaid expansion and access to care among cancer survivors: A baseline overview. *Journal of Cancer Survivorship*, *10(*3), 583-592. https://doi.org/10.1007/s11764-015-0504-5

Tashakkori, A., & Creswell, J. W. (2008). Mixed methodology across disciplines. *Journal of Mixed Methods Research*, *2*(1). https://doi.org/10.1177/1558689807309913

Tashakkori, A., & Teddlie, C. (2008). Introduction to mixed method and mixed model studies in the social and behavioral sciences. *The Mixed Methods Reader*, 726. https://dx.doi.org/10.4135/9781446262566

Tashakkori, A., Teddlie, C., & Teddlie, C. B. (1998). *Mixed methodology: Combining qualitative and quantitative approaches* (Vol. 46). Sage.

Tate, C. E., Venechuk, G., Pierce, K., Khazanie, P., Ingle, M. P., Morris, M. A., Allen, L. A., & Matlock, D. D. (2021). Development of a decision aid for patients and families considering hospice. *Journal of Palliative Medicine*, *24*(4), 505–513. https://doi.org/10.1089/jpm.2020.0250

Tavakol, M., & Sandars, J. (2014). Quantitative and qualitative methods in medical education research: AMEE Guide No 90: Part II. *Medical Teacher*, *36*(10), 838-848. https://doi.org/10.3109/0142159X.2014.915297

Taylor, M. R., Scott, S. R., Steineck, A., & Rosenberg, A. R. (2021). Objectifying the subjective: The use of heart rate variability as a psychosocial symptom biomarker in hospice and palliative care research. *Journal of Pain and Symptom*, *62*(3), e315-e321. https://doi.org/10.1016/j.jpainsymman.2021.04.015

Teno, J. M., Gozalo, P. L., Lee, I. C., Kuo, S., Spence, C., Connor, S. R., & Casarett, D. J. (2011). Does hospice improve quality of care for persons dying from dementia? *Journal of the American Geriatrics Society*, *59*(8), 1531–1536. https://doi.org/10.1111/j.1532-5415.2011.03505.x

Terrell, S.R. (2012). Mixed-methods research methodologies. *The Qualitative Report*, *17*(1), 254-280. https://doi.org/10.46743/2160-3715/2012.1819

The Belmont Report (2021). Office of the Secretary, ethical principles and guidelines for the protection of human subjects of research. https://www.hhs.gov/ohrp/sites/default/files/the-belmont-report-508c_FINAL.pdf

The hospice interdisciplinary team (2020). *Fast Facts for The Hospice Nurse*. https://doi.org/10.1891/9780826164643.0004

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, (2021). *The Belmont Report*. U. S. Department of Health and Human Services. https://www.hhs.gov/ohrp/sites/default/files/the-belmont-report-508c_FINAL.pdf

The U.S. Department. of Health & Human Service. (2023). *Hospice and Palliative Care*. https:// www.hhs.gov/guidance/document/hospice-and-palliative-care.

Thompson, J. W., Carlson, M. D., & Bradley, E. H. (2012). U.S. hospice industry experienced considerable turbulence from changes in ownership, growth, and shift to for-profit status. *Health Affairs*, *31*(6), 1286-1293. https://doi.org/10.1377/hlthaff.2011.1247

Tripathi, N. (2018). A valuation of Abraham Maslow's theory of self-actualization for the enhancement of quality of life. *Indian Journal of Health and Wellbeing*, *9*(3), 499-504. https://web.s.ebscohost.com/abstract?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=22295356&AN=129285067&h=kZuDRmtnN482RhFlwgpw8gUMgpUWfWIkPfY8RP52sTdt9p4PdifPEehjInPbnGar2PQpiaoSeuoZOoS3FEfiSA%3d%3d&crl=c&resultNs=AdminWebAuth&resultLocal=ErrCrlNotAuth&crlhashurl=login.aspx%3fdirect%3dtrue%26profile%3dehost%26scope%3dsite%26authtype%3dcrawler%26jrnl%3d22295356%26AN%3d129285067

Turner, P. (2017). Defining talent in the health sector. *Talent Management in Healthcare*, 39–64. https://doi.org/10.1007/978-3-319-57888-0_3

Uştuk, Ö., & Çomoğlu, İ. (2021). Reflexive professional development in reflective practice: What lesson study can offer. *International Journal for Lesson & Learning Studies*. https://doi.org/10.1108/IJLLS-12-2020-0092

Van Der Walt, J. L. (2020). Interpretivism-constructivism as a research method in the humanities and social sciences-more to it than meets the eye. *International Journal of Philosophy and Theology*, *8*(1), 59-68. https://doi.org/10.15640/ijpt.v8n.1a4~~htt~~

Ventegodt, S., Merrick, J., & Andersen, N. J. (2003). Quality of life theory I. The theory: An integrative theory of the global quality of life concept. *The Scientific World Journal*, *3*, 1030-1040. https://doi.org/10.1100/tsw.2003.82

Viftrup, D.T., Hvidt, N.C., & Prinds, C. (2021). Dignity in end-of-life care at hospice: An action research study. *Scandinavian Journal of Caring Sciences, 35*(2), 420-429. https://doi.org/10.1111/scs.12872

Vilma, Ž. (2018). Implementing ethical principles in social research: Challenges, possibilities, and limitations. *Vocational Training: Research and Realities*, *29*, 19-43. https://dio.org10.2478 /vtrr-2018-0003 V

Walker, S., & Mcmillan, J. (2021). Ethical concepts in clinical decision-making and ethics teaching. *The History and Bioethics of Medical Education,*130-146. https://doi.org/10.4324/9781003107156-11

Walshe, C., Barnes, H., Turner, M., & Hughes, S. (2021). Constructing a new role for family care and volunteers providing care towards the end of life: an action research approach exploring a new model of hospice care. *Health & Social Care in the Community*, *29*(3), 837-845. https://doi.org/10.1111/hsc.13315

Wang, J., Simmons, S. F., Maxwell, C. A., Schlundt, D. G., & Mion, L. C. (2018). Home health nurses' perspectives and care processes related to older persons with frailty and depression: A mixed-method pilot study. *Journal of Community Health Nursing*, *35*(3), 118-136. https://dio.org/10.1080/07370016.2018.1475799

Wang, Y., Huang, Y., Zheng, R., Yue, X., & Dong, F. (2023). Intern nursing students' perceived barriers to providing end-of-life care for dying cancer patients in a death taboo cultural context: A qualitative study. *Asia-Pacific Journal of Oncology Nursing*, *10*(4), 100210. https://doi.org/10.1016/j.apjon.2023.100210

Watkins, D. C., & Gioia, D. (2015). *Mixed methods research.* Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199747450.001.0001

Wexler, A., Choi, R. J., Ramayya, A. G., Sharma, N., McShane, B. J., Buch, L. Y., & Klein, E. (2021). Ethical issues in intraoperative neuroscience research: Assessing subjects' recall of informed consent and motivations for participation. *AJOB Empirical Bioethics,13*(1), 110. https://doi.org/10.1080/23294515.2021.1941415

White, S. E. (2016). *A practical approach to analyzing healthcare data* (3rd ed.). American Health Information Management Association. http://www.ahimapress.org/white5276/

Willaschek, M. (2011). Agency, autonomy, and moral obligation. In C. Fehige & U. Wessels (Ed.), *Preferences* (pp. 176-203). https://doi.org/10.1515/9783110804294.176

Williamson, S., Beaver, K., & Langton, S. (2020). Exploring health care professionals' views on alternative approaches to cancer follow-up and barriers and facilitators to implementation of a recovery package. *European Journal of Oncology Nursing*, *46*, 101759. https://doi.org/pii/S1462388920300399

World Health Organization. (2021a). *Cancer*. World Health Organization. https://www.who.int/health-topics/cancer#tab=tab_1

World Health Organization. (2021b). *Cancer*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/cancer

World Health Organization. (2018). *Delivering quality health services: A global imperative*. OECD Publishing.

Wolters, M. W., Michielin, O., Bastiaannet, E., Beishon, M., Catalano, O., del Marmol, V., Delgado-Bolton, R., Dendale, R., Trill, M. D., Ferrari, A., Forsea, A.-M., Kreckel, H., Lovey, J., Luyten, G., Massi, D., Mohr, P., Oberst, S., Pereira, P., Prata, J. P., & Namedi, P. (2018). ECCO essential requirements for quality cancer care: Melanoma. *Critical Reviews in Oncology/Hematology*, *122*, 164–178. https://doi.org/10.1016/j.critrevonc.2017.12.020

Wright, P. M. (2020). *Fast facts for the hospice nurse* (2nd ed.). Springer Publishing. https://doi.org/10.1891/9780826164643.0004

Xue, H., & Desmet, P. M. (2019). Researcher introspection for experience-driven design research. *Design Studies, 63*. https://doi.org/10.1016/j.destud.2019.03.001

Yarbrough, K. R., Gansler, T., Wender, R. C., Cullen, K. J., & Brawley, O. W. (2019).

Minimizing the burden of cancer in the United States: Goals for a high-performing health care system. *CA: A Cancer Journal for Clinicians*, *69*(3), 166-183. https://doi.org/10.3322/caac.21556

Yesil, S., & Doğan, I. F. (2019). Exploring the relationship between social capital, innovation capability, and innovation. *Innovation, 21*(4), 506-532. https://doi.org/10.1080/14479338.2019.1585187

Yip, C., Han, N. R., & Song, B. L. (2016). Legal and ethical issues in research. *Indian Journal of Anesthesia, 60*(9), 684-688. https://doi.org/10.4103/0019-5049.190627

Zhang, S. N., Li, Y. Q., Liu, C. H., & Ruan, W. Q. (2021). Does live performance play a critical role in building destination brand equity—A mixed-method study of "Impression Dahongpao." *Journal of Retailing and Consumer Services,* 59, 102392. https://doi.org/10.1016/j.jretconser.2020.102392

Zimmermann, C., Swami, N., Krzyzanowska, M., Leighl, N., Rydall, A., Rodin, G., Tannock, I., & Hannon, B. (2016). Perceptions of palliative care among patients with advanced cancer and their\caregivers. *Cmaj*, *188*(10), E217-E227. https://doi.org/10.1503/cmaj.151171

Zohaib, M. (2013). Mixed-method research: Instruments, validity, reliability and reporting findings. *Theory & Practice in Language Studies*, *3*(2). http://dx.doi.org/10.4304/tpls.3.2.254-262

Ziwei, K., Mengjiao, C., Yongjie, Z., Mengqi, Z., & Yeqin, Y. (2023). Optimizing palliative care education through undergraduate nursing students' perceptions: Application of importance-performance analysis and Borich needs assessment model. *Nurse Education Today*, 105719. https://doi.org/10.1016/j.nedt.2023.105719

Appendix A

Final and Introduction Informed Consent

This online pre-interview and the final survey will include questions regarding demographic and background information, such as age, race/ethnicity, and gender.

1. The current age of the participant?
2. The current location of the participant?
3. Race/ethnicity and gender of the participant?
4. Work background of the participant?

Activities:

If you participate in this research, you will be asked to:

1. Participate in a 30-minute interview.
2. Answer follow-up questions for clarification if needed

Eligibility:

You are eligible to participate in this research if you:

1. Have been a patient/staff/leadership with Hospice System.
2. Are with the United States of America.
3. Are fluent in English.
4. Are not a minor.

You are not eligible to participate in this research if you:

1. Are not a patient/staff/leadership.
2. Are a minor.

Risks:

No anticipated hazards are associated. To minimize the impact of any hazard, participants may and can skip any questions, or stop participation at any time.

Benefits:

If you decide to participate, a compensation of $50 in the form of an Amazon Gift

Card will be awarded upon full completion of all the survey questions.

Confidentiality:

The information provided will be kept classified and private to the extent of the law. Data research record and result will be provided to the dissertation chair, dissertation committee and other researchers. The Institutional Review Board may also review my research and view collected information.

The researcher will secure private information with these steps (emails address and names): keeping all records on a flash drive, locking all computer files with a password, and employing encryption. Data would be kept no longer than three years and will be destroyed afterward.

Contact Information:

For any questions, I can be contacted at, [redacted] and telephone number (757) [redacted]. My dissertation chair's name is email at Dr. Geri Rosol, Ph.D. M.H.A**.** If you have any further questions about your rights in the study, please contact the Institutional Review Board at irb@liberty.edu or (434) 582-2000

.

Informed Consent

Signature_____________________________________Date_____________
Print:

Researcher

Signature____________________________Date____________________

Appendix B

Patient and Leadership Experience Form

This set of questions focuses on experience within strategies and assessment of hospice patient experience and first-hand patient account experiences regarding the quality of care or improving quality. The survey is structured from a scale of 1 to 5 from strongly agree to strongly disagree.

Please check one of the boxes below:

I consent to participate ______ ☐ Please start filling out the questionnaire promptly.

I refuse to participate ______☐ I completed this questionnaire in another online doctoral Program.

There are seven research questions which are either quantitative or qualitative in nature. Each quantitative Research Question has a corresponding survey question, and it is very essential that all are answered. This should take you less than 30 minutes. Each answer will be handled with confidentiality. Each qualitative Research Question will be answered via an interview.

Please circle/Check your response to the following matters. Be sure to answer each question.

Seven Research Questions :

Quantitative Question :

RQ1. What are the key management issues affecting the quality of hospice care for cancer patients?

Qualitative Question

RQ2. How does each management issue contribute to patient outcomes?

RQ3. How does the assessment of patient need in cancer care contribute to quality control issues and patient satisfaction?

Quantitative Question

RQ4. What is the relationship between care needs for different types of cancer patients and patient satisfaction?

RQ5. What improvement interventions should U.S. hospitals adopt for the efficient management of cancer patients?

RQ6. What evidence-based care interventions have been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients?

RQ7. To what extent if any is there a relationship linking aggressive symptom management and intense hospice care to management issues, resulting in high-quality hospice or low-quality care?

Quantitative Survey Questions Relating to Research Questions:

RQ1. What are the key management issues affecting the quality of hospice care for cancer?

A. How would you rate where your hospice care was delivered?

Likert Scale range of 1 to 5
1 2 3 4 5 **Very Good, Good, Satisfactory, Somewhat Satisfactory, Very Unsatisfactory**
How would you rate where your hospice care was delivered?

RQ4. What is the relationship between care needs for different types of cancer patients and patient satisfaction?

B. How satisfied were you with the type of cancer services you received?

Likert Scale range of 1 to 5
1 2 3 4 5 **Very Good, Good, Satisfactory, Somewhat Satisfactory, Very Unsatisfactory**
How satisfied were you with the type of cancer services you received?

RQ5. What improvement interventions should U.S. hospitals adopt for the efficient management of cancer patients?

C. How important are performance indicators in the efficient management of cancer patients?

Likert Scale range of 1 to 5
1 2 3 4 5 **Very Important Moderately Important Slightly Important Not Important**
How important are performance indicators in the efficient management of cancer patients?

RQ6. What evidence-based care interventions have been implemented in the U.S. healthcare system to improve treatment outcomes and satisfaction among cancer patients?

D. How important are evidence-based guidelines and protocols to you in getting hospice services?

Likert Scale range of 1 to 5
1 ***2*** ***3*** ***4*** ***5*** **Very Important Moderately Important Slightly Important Not Important**
How important are evidence-based guidelines and protocols to you in getting hospice services?

RQ7. To what extent is there a relationship linking aggressive symptom management and intense hospice care in providing high-quality hospice care resulting in low-quality care and management issues?

E. To what extent do you feel management issues influence the quality of hospice care for cancer patients?

Likert Scale range of 1 to 5
1 – Not at All influential, 2 – Slightly Influential, 3 – Somewhat Influential, 4 – Very Influential, 5 – Extremely Influential
To what extent do you feel management issues influence the quality of hospice care for cancer patients?

Phase II

Qualitative Survey Open-ended

RQ2. How does each management issue contribute to patient outcomes?

Questionnaire: A. What experience or miscommunication have you had with a hospice center? How did you solve the problem?

____

____

____

RQ3. How does the assessment of patient need in cancer care contribute to quality control issues and patient satisfaction?

Questionnaire: B. What has been your experience in dealing with the staff, doctors, nurses, and leadership? Give me an example

____

____

____

Appendix C

Interview Guide Introductory Statement

Hello. Thank you for deciding to join my study on An Assessment of Hospice Patient Experience with Cancer Care Services in the United States Hospitals: A Mixed-Method Study. My name is Dr. Femi Obasun. I am conducting this study to conclude my doctoral of Health Management dissertation. Your participation is voluntary, and the participant can stop at any time or any reason within the research or interview.

The interview would be for about 30 minutes. Your patient's or first-hand patient account experiences regarding the quality of care or improving quality are valuable to research purposes in improving care in hospice centers. The interview will be recorded to ensure my accuracy during data collection. Collected material will be confidentially stored for three years and password-protected on a computer. Participant names will be private from any public records. Thank you for your participation!

Demographic questions:

- What is your gender?
- What is your race?

Former Appendix B

Participant Recruitment Email : Potential Participant

Dear (Name):

My name is Dr. Femi Obasun, and I am finishing my doctoral dissertation at the School of Health and Business Management at Liberty University, Lynchburg, VA. You have been identified as a current or past patient or member of the leadership team who had services within the hospice system in the United States. I anticipate that you would consent to participate in my dissertation study on An Assessment of Hospice Patient Experience with Cancer Care Services in the United States Hospitals: A Mixed-Method Study

This study is being conducted to identify and analyze the quality of care received or administered by workers and leadership associated with the pursuit of having a better quality of care. The information will be necessary to understand how to better the quality of care and programs. You have been selected as a participant in this study, as your input will help understand the problem. The research results may help improve the quality of hospice care further.

To participate in this study, you are being asked to complete an online pre-interview survey that will include questions regarding demographic and background information, such as age, race/ethnicity, and gender. The interview will be arranged at your convenience and will be held by email, Zoom, and/or phone. One-on-one interviews per phone will be digitally recorded, and it is anticipated that each interview will average 30 minutes in length, for which you will be compensated $50.00 via an Amazon.com gift card.

Please note that your participation is voluntary, and if you agree to participate in the study, you may leave the study at any time. All information you provide will be confidential, and no identifying information about any study participant will be disclosed. Geri Rosol, Ph.D. M.H.A**.** is the primary faculty Chair for this study. You may contact her at gfrosol@liberty.edu if you have any further questions.

Additionally, you will receive an email to confirm the interview before the scheduled interview. If you are interested in participating in this study, please email me at: fsobasun@liberty.edu. I will follow up with interview scheduling information. Thank you for your time and consideration in taking part in this study.

Warm regards,

Dr. Femi Obasun, Ph.D., DBA
Liberty University

Appendix D

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
The key management issues affecting the quality of hospice care for cancer patients	96	3.00	5.00	4.4063	.62539
Valid N (listwise)	96				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
The assessment of patient needs in cancer care contribute to quality control issues and patient satisfaction?	96	4.00	5.00	4.6667	.47388
Valid N (listwise)	96				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Each management issue contributes to patient outcomes?	96	3.00	5.00	4.1979	.69008
Valid N (listwise)	96				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Improvement interventions should U.S. hospitals adopt for the efficient management of cancer patients?	96	3.00	5.00	4.1458	.68023
Valid N (listwise)	96				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
There a relationship linking aggressive symptom management and intense hospice care to provide high-quality hospice care results in low-quality care and management issues	96	3.00	5.00	4.0208	.79444
Valid N (listwise)	96				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
The relationship between care needs for different types of cancer patients and patient satisfaction	96	3.00	5.00	4.1458	.79444
Valid N (listwise)	96				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Each management issue contributes to patient outcomes?	96	3.00	5.00	4.1979	.69008
Valid N (listwise)	96				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
The assessment of patient needs in cancer care contribute to quality control issues and patient satisfaction?	96	4.00	5.00	4.6667	.47388
Valid N (listwise)	96				

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
The key management issues affecting the quality of hospice care for cancer patients	96	3.00	5.00	4.4063	.62539
Valid N (listwise)	96				

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.178[a]	.032	.021	.61872

a. Predictors: (Constant), the assessment of patient need in cancer care contribute to quality control issues and patient satisfaction?

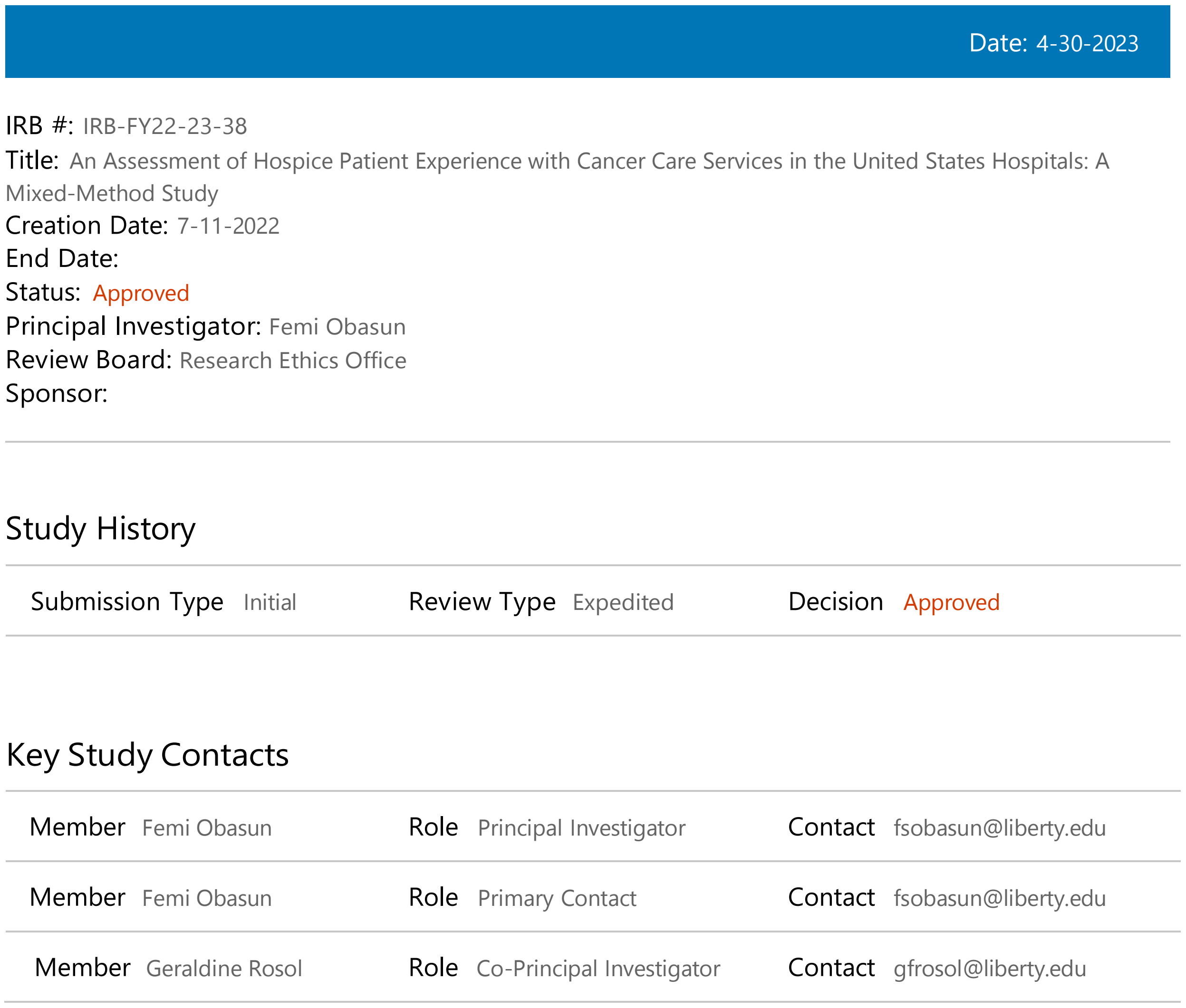
Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.313	.628		5.272	.000
	the assessment of patient needs in cancer care contribute to quality control issues and patient satisfaction?	.234	.134	.178	1.750	.083

a. Dependent Variable: the key management issues affecting the quality of hospice care for cancer patients

Appendix E

IRB Approval #IRB-FY22-23-38



Date: 4-30-2023

IRB #: IRB-FY22-23-38
Title: An Assessment of Hospice Patient Experience with Cancer Care Services in the United States Hospitals: A Mixed-Method Study
Creation Date: 7-11-2022
End Date:
Status: Approved
Principal Investigator: Femi Obasun
Review Board: Research Ethics Office
Sponsor:

Study History

Submission Type	Review Type	Decision
Initial	Expedited	Approved

Key Study Contacts

Member	Role	Contact
Femi Obasun	Principal Investigator	fsobasun@liberty.edu
Femi Obasun	Primary Contact	fsobasun@liberty.edu
Geraldine Rosol	Co-Principal Investigator	gfrosol@liberty.edu

Appendix F

Research Institution
HUMAN RESEARCH PROTECTIONS PROGRAM

Authorization for the Use and Disclosure of Identifiable Health Information for Research Purposes

You have been asked to be part of a research study under the direction of Dr. Femi Obasun, PhD, the Principal Investigator, and his or her research team. The study is called An Assessment of Hospice Patients' Experience from Cancer Care Services in the United States Hospitals: A Mixed-Method Study**.** The purpose of the study is to address management's failure to provide high-quality care in hospice healthcare facilities in the United States, resulting in quality control issues and customer dissatisfaction among cancer patients**.**

This authorization form describes information about you and about your health that will be obtained by the researchers when you participate in the research study. Health information is considered "protected health information" when it may directly identify you as an individual. By signing this form, you are agreeing to permit the researchers and/or other parties (described in detail below) to have access to this information. If there are any parts of this form that you do not understand, please be sure to ask us for further clarification.

1. What protected health information will be collected about you as part of this research study?

☐ information from your medical records:
General description of information:

---

2. Who is authorized to provide and collect this information?

☐ Research Institution
☐ Liberty University
☑ Principal Investigator or listed designee

☐ Other:____

3. With whom may your protected health information be shared?

Your health information may be shared with others outside of the research group for purposes directly related to the conduct of this research study or as required by law, including but not limited to:

☐ clinical staff not involved in this research study who may become involved in your care if it is potentially relevant to your treatment
☐ the sponsor of this research study, list specific sponsor, cooperative group, etc., or its agents

Dr. Femi Obasun:

☐ other medical investigators/centers/institutions participating in this research study (Research Institution)*:*

☐ the following ***[Research Institution, Dr. Femi Obasun, PhD, etc.]***:

Your information may also be shared with individuals responsible for general oversight and compliance of research activities. Examples of this include the institution's Privacy and Security Officers or other internal oversight staff, Safety Monitoring Boards, an Institutional Review Board, and accrediting bodies, or with certain government oversight agencies that have authority over the research including the Department of Health and Human Services (HHS), the Food and Drug Administration (FDA), the National Institutes of Health (NIH), and the Office of Human Research Protections (OHRP). Your information may also be shared with other entities as permitted or required by law. All reasonable efforts will be used to protect the confidentiality of your individually identifiable health information that may be shared with others as described above.

All reasonable efforts will be used to protect the confidentiality of your protected health information. There is the potential for individually identifiable information and the associated health information obtained with this authorization to be re-disclosed by the recipient(s). After such a disclosure, the information may no longer be protected by the terms of this authorization against further re-disclosure.

4. How long will this information be kept by the Principal Investigator?

[choose one: a, b, or c]

☐ a) This authorization has no expiration date. The researchers may continue to rely on this authorization to obtain and use protected health information about you unless you revoke this authorization in writing.

[-or-]

☐ b) This authorization will expire by *[date or "end of the research study"].* After that time, this authorization may not be used to acquire additional information about you.

[-or-]

☑ c) This authorization will expire by *[date or "end of the research study"]*. After that time, this authorization may not be used to acquire additional information about you and the protected health information collected on you for the purposes of this study will be destroyed.

[check if applicable – note: only applies if a) or b) above are checked]

☐ Your protected health information will be held confidentially by the researcher indefinitely. Any future study using this information that falls outside the scope of this current study will be required to follow guidelines designed to govern access to that information and to protect the privacy of that information.

5. What are your rights after signing this authorization?

You have the right to revoke this authorization at any time. If you withdraw your authorization, no additional efforts to collect individually identifiable health information about you will be made. You should know, however, that protected health information acquired using this authorization prior to its withdrawal may continue to be used to the extent that the investigator(s) have already relied on your permission to conduct the research. If you chose to withdraw this authorization, you must do so in writing to the following individual(s):

Dr. Femi Obasun PhD of Research Institution of 7007 Backlick Ct, Suite 250, Springfield, VA 22151.

If you send us a request to withdraw your authorization, we will forward that request to the institutions we have shared it with in order to collect your individually identifiable health information. You may also withdraw this authorization directly with those institutions by writing to the following:

Research Institution of 7007 Backlick Ct, Suite 250, Springfield, VA 22151.

6. What will happen if you decide not to sign this authorization?

Refusing to sign this authorization will not affect the present or future care you receive at this institution and will not cause any penalty or loss of benefits to which you are otherwise entitled. If you decide not to sign this authorization, you will not be able to participate in the research study.

This document constitutes a direct request on my part to the entities identified above to provide the protected health information described in this document in accordance with 45 CFR 164.524 *Access of individuals to protected health information* and authorizes the release of this information to the authorized recipients identified above. Furthermore, this document authorizes the recipients identified above to act on my behalf as my personal representative in seeking this information.

Name (please print) ____

Signature____

Date: ____

After signing, you will be provided with a signed copy of this authorization form.

Section for Personal Representatives (e.g., Legally Authorized Representatives, or for children, Parents/Guardians):

Relationship of personal representative to the participant or authority to act for the participant:

Name of Participant (print) ____

Name (please print) ____

Signature____

Date: ____

Appendix F

Approved Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

November 14, 2022

Femi Obasun
Geraldine Rosol

Re: IRB Approval - IRB-FY22-23-38 An Assessment of Hospice Patient Experience with Cancer Care Services in the United States Hospitals: A Mixed-Method Study

Dear Femi Obasun, Geraldine Rosol,

We are pleased to inform you that your study has been approved by the Liberty University Institutional Review Board (IRB). This approval is extended to you for one year from the following date: November 14, 2022. If you need to make changes to the methodology as it pertains to human subjects, you must submit a modification to the IRB. Modifications can be completed through your Cayuse IRB account.

Your study falls under the expedited review category (45 CFR 46.110), which is applicable to specific, minimal risk studies and minor changes to approved studies for the following reason(s):

5. Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Thank you for your cooperation with the IRB, and we wish you well with your research project.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office