Natural Resources for Human Health
eISSN: 2583-1194

Original Research

Received 15 Jan 2024
Revised 25 Jan 2024
Accepted 10 Feb 2024

Natural Resources for Human Health 2024, Vol. 4 (4): 552-566

KEYWORDS:
Health Administration; Healthcare Management; Patient Satisfaction; Patient Experience; Service Quality; Operational Efficiency; Organizational Culture; Healthcare Finance; Value-Based Care; Quality Improvement; Health Information Technology; Patient-Centered Care.

The Relationship Between Health Administration, Nursing Services and Patient Satisfaction

Ali Bashan Al-Ruwaili[1], Nasser Jabi Al-Ruwaili[2], Mohammad Awijan Al-Rouili[3], Fahad Daher Al-Anzi[4]

[1] Senior Administration Specialist, Northern Borders Health Cluster Hospitals, Turaif General Hospital, Turaif, Saudi Arabia
[2] Senior Health Administration Specialist, Director of the Specialized Diabetes Center, Turaif, Northern boarder health cluster, Saudi Arabia
[3] Health Administration Specialist, Director of Turaif Central Healthcare Center, Northern Hoarder Health Cluster, Turaif, Saudi Arabia
[4] Health Administration Specialist, Financial Management, Northern Border Health Cluster, Turaif, Saudi Arabia

ABSTRACT: This research paper provides a comprehensive analysis of the multifaceted and causal relationship between health administration and patient satisfaction within modern healthcare systems. It argues that patient satisfaction, a critical outcome reflecting the quality of the care experience, is not merely a byproduct of clinical skill but is fundamentally shaped by the strategic, operational, and cultural decisions of healthcare administration. The paper employs a multi-dimensional framework, exploring how various administrative domains directly and indirectly influence patient perceptions. It examines the foundational theories linking management to service quality, such as the Donabedian Structure-Process-Outcome model and SERVQUAL, to establish a conceptual pathway from administrative action to patient outcome. Subsequently, the analysis delves into specific administrative levers: operational efficiency's impact on the patient journey through wait times and resource management; the mediating role of human capital and organizational culture in enabling empathetic, patient-centered staff interactions; the dual potential of technology and data systems to enhance or hinder engagement; and the overarching strategic framework created by financial models, policy, and quality governance, which set the incentives for prioritizing the patient experience. The synthesis concludes that effective health administration is the essential, integrating force that aligns an organization's structure, processes, and culture to systematically deliver care that is not only clinically excellent but also consistently satisfying. The findings underscore that investments in administrative excellence are direct investments in patient loyalty, clinical outcomes, and financial sustainability in an era of value-based care.

INTRODUCTION

The contemporary healthcare landscape is characterized by unprecedented complexity, driven by technological advancements, evolving patient expectations, escalating costs, and an intensified focus on measurable outcomes. Within this intricate ecosystem, the pursuit of **patient satisfaction** has emerged as a paramount objective, transcending its traditional role as a mere indicator of pleasantry to become a critical metric for quality, financial viability, and institutional reputation. Concurrently, the field of **health administration** has evolved from a background support function to a central, strategic discipline that orchestrates all facets of healthcare delivery. This research paper posits that there exists a profound and multifaceted relationship between the practices, principles, and policies of health administration and the levels of satisfaction experienced by patients. It

is a relationship that is not merely correlational but often causal, where administrative decisions directly shape the patient journey, influence clinical outcomes, and ultimately define the care experience. This paper will undertake a comprehensive exploration of this dynamic relationship, arguing that effective health administration is an indispensable, though often underappreciated, determinant of patient satisfaction.

Patient satisfaction is a multidimensional construct encompassing a patient's evaluation of all aspects of their healthcare encounter, including interpersonal, technical, and environmental factors [1]. It reflects the gap between a patient's expectations of care and their actual perceptions of the care received [2]. High levels of satisfaction are associated with numerous positive outcomes, including improved patient adherence to treatment plans, better clinical outcomes, enhanced patient loyalty, positive word-of-mouth, and reduced risk of litigation [3, 4]. Furthermore, in many healthcare systems, reimbursement models are increasingly tied to patient-reported experience measures (PREMs) and satisfaction scores, making them directly consequential to institutional financial health [5]. Therefore, understanding the drivers of patient satisfaction is not just an ethical imperative for patient-centered care but a strategic necessity for organizational sustainability.

Health administration, encompassing the leadership, management, and administration of public health systems, hospitals, hospital networks, and other healthcare organizations, serves as the operational backbone of these institutions [6]. Its domain is vast, covering strategic planning, financial management, human resources, health information systems, facility management, policy implementation, and quality assurance. The decisions made by health administrators—from allocating budgets and staffing units to designing clinical workflows and selecting information technology—create the infrastructure within which clinical care occurs. This administrative infrastructure sets the stage for the patient experience. For instance, an efficiently managed appointment scheduling system reduces wait times, a well-designed facility layout minimizes patient confusion and anxiety, and a robust staff training program on communication enhances clinician-patient interactions. Each of these is fundamentally an administrative function with direct patient-facing consequences.

The nexus between administration and satisfaction can be examined through several key administrative domains. First, **resource allocation and operational efficiency** are primary drivers. Long wait times, whether in emergency departments, outpatient clinics, or for diagnostic tests, are consistently cited as major sources of patient dissatisfaction [7]. Effective administration streamlines processes, optimizes staff schedules, and manages patient flow using principles from operations management and industrial engineering, directly reducing these friction points [8]. Second, **human resource management** within healthcare is critically administrative. Staffing levels, nurse-to-patient ratios, employee morale, and the cultivation of a patient-centric culture are all managed through administrative policies. Research demonstrates a clear link between adequate staffing, supportive work environments for clinicians, and higher patient satisfaction scores [9]. A burned-out, understaffed clinical team is less likely to provide the empathetic, attentive care that patients value.

Third, the implementation and management of **Health Information Technology (HIT)**, such as Electronic Health Records (EHRs) and patient portals, fall squarely under health administration. While intended to improve care coordination, poorly implemented HIT can create barriers, leading to clinician frustration and a perception of depersonalized care as providers focus on screens rather than patients [10]. Conversely, well-managed systems that facilitate communication, provide patients with access to their information, and support clinical decision-making can significantly enhance satisfaction [11]. Fourth, **quality and safety initiatives**, led by administration, directly impact patient trust and satisfaction. Transparent reporting of outcomes, systematic approaches to reducing medical errors, and continuous quality improvement projects demonstrate an institutional commitment to excellence that patients can perceive and appreciate [12]. However, the relationship is fraught with challenges. Administrators often face the difficult task of balancing competing priorities: financial constraints, regulatory compliance, clinical autonomy, and patient demands. Cost-containment measures can sometimes appear to conflict with patient comfort or convenience. The rise of consumerism in healthcare further intensifies this, as patients, armed with more information, have higher expectations for service, convenience, and involvement in their care decisions [13].

Defining the Core Concepts: Health Administration and Patient Satisfaction

Any rigorous examination of the relationship between two complex phenomena must begin with a clear and nuanced understanding of the constituent concepts themselves. To analyze how health administration influences patient satisfaction, it is imperative to first delineate what these terms encompass, their evolving scope, and their key dimensions. This foundational section provides the conceptual framework upon which the subsequent analysis is built, establishing that both health

administration and patient satisfaction are multidimensional, dynamic, and critically interdependent constructs in modern healthcare.

Health Administration: The Architecture of Healthcare Delivery

Health administration, often used interchangeably with healthcare management or healthcare administration, refers to the comprehensive field concerned with the leadership, management, and administration of public health systems, hospitals, hospital networks, and the entire spectrum of healthcare organizations [14]. It is the discipline that ensures the seamless operation of the healthcare system's infrastructure. Far beyond mere bureaucratic function, it is the strategic and operational engine that translates policy into practice, resources into services, and clinical knowledge into accessible care. Historically viewed as a background support role, the scope of health administration has expanded dramatically. It now encompasses a vast array of functions including, but not limited to, strategic planning and policy analysis, financial management and healthcare economics, human resources management for clinical and non-clinical staff, health information systems management, operations and logistics, marketing and community relations, legal and ethical compliance, and continuous quality and performance improvement [15].

The modern health administrator operates at the intersection of business acumen, public policy, and clinical understanding. Their role is fundamentally one of systems thinking: creating, maintaining, and optimizing the complex system within which healing occurs [16]. This involves making critical decisions about resource allocation—determining how financial capital, human expertise, technological tools, and physical space are distributed. For instance, deciding on nurse-to-patient ratios is both a clinical safety issue and a profound administrative decision with direct budgetary and operational implications. Similarly, investing in a new electronic health record (EHR) system, redesigning a clinic's patient flow, or implementing a staff training program on cultural competency are all quintessential acts of health administration. The effectiveness of these decisions creates the "architecture" of the patient experience, shaping everything from the ease of scheduling an appointment to the environment in which care is received and the efficiency of the billing process [17]. Therefore, health administration is not peripheral to care; it is the foundational platform that enables, constrains, and shapes all clinical activities and patient interactions.

Patient Satisfaction: A Multifaceted Measure of the Care Experience

Patient satisfaction, on the other hand, is the subjective measure of the extent to which a patient's expectations and desires regarding their healthcare encounter are met. It is a critical outcome indicator that reflects the patient's evaluation of both the "what" and the "how" of care. The "what" pertains to the technical and clinical aspects: the perceived competence of providers, the accuracy of diagnosis, the effectiveness of treatment, and the achievement of desired health outcomes. The "how," often equally weighted, encompasses the interpersonal and experiential dimensions: communication, empathy, respect, dignity, emotional support, and the overall service quality experienced throughout the care journey [18].

It is crucial to understand that patient satisfaction is not a singular or simple metric. It is a multidimensional construct shaped by a confluence of factors. These include, as identified by numerous studies: Interpersonal factors (quality of communication, perceived empathy and respect from all staff, involvement in decision-making); Technical and clinical factors (perceived skill and competence of caregivers, outcomes of care); Administrative and logistical factors (waiting times, appointment access, ease of navigation, cleanliness, comfort of facilities, billing clarity); Contextual factors (patient's own health status, prior expectations, cultural background, and socio-demographic characteristics) [19]. This multifaceted nature means that satisfaction is influenced at every touchpoint, from the first phone call to the final follow-up, and by every individual, from the receptionist to the surgeon.

Furthermore, the conceptualization of patient satisfaction has evolved alongside the broader movement toward patient-centered care. This paradigm shift moves away from a paternalistic model ("doctor knows best") to a collaborative partnership where the patient's values, preferences, and expressed needs guide all clinical decisions [20]. In this context, satisfaction is intrinsically linked to concepts like patient experience (the sum of all interactions) and patient-reported outcomes (PROs). It is measured through sophisticated tools such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in the United States, which standardizes the collection and public reporting of patient perspectives on topics like nurse communication, pain management, and discharge information [21]. High satisfaction scores are thus increasingly seen not as a luxury, but as a marker of high-quality, respectful, and effective care that aligns with the principles of patient-centeredness.

The Conceptual Intersection: Where Administration Meets Experience

The definitions of these two core concepts reveal their inherent interconnection. Health administration is fundamentally concerned with designing and managing the **processes, structures, and environments** that constitute the healthcare system. Patient satisfaction is the **subjective outcome** resulting from an individual's journey through that very system. The relationship is, therefore, one of cause and effect, or at the very least, of profound influence. Every administrative decision—be it strategic, financial, operational, or human-resource related—creates conditions that either facilitate or hinder the delivery of satisfying care.

For example, an administrative policy to implement centralized scheduling (a process) aims to improve efficiency. Its success directly affects a patient's ability to get a convenient appointment (an experiential factor). An administrative investment in training staff on empathy and active listening (a human resource development) aims to improve communication skills. This directly influences a patient's perception of being heard and cared for (a key dimension of satisfaction). Conversely, an administrative decision driven solely by short-term cost-cutting, such as reducing support staff or extending equipment replacement cycles, may lead to longer wait times, harried clinicians, and outdated facilities, thereby eroding multiple dimensions of patient satisfaction [22]. Thus, the concepts are bound in a continuous feedback loop: patient satisfaction data is a key performance indicator that informs administrative strategy, which in turn modifies the system to improve future satisfaction [23].

Theoretical Frameworks: Linking Management to Service Quality

To move beyond observing the correlation between health administration and patient satisfaction and toward a deeper, predictive understanding of their relationship, one must engage with the theoretical frameworks that explicitly link organizational management to service quality outcomes. These models provide structured lenses through which the complex machinery of healthcare delivery can be analyzed, offering explanations for how administrative "inputs" and "processes" translate into patient-level "outputs" like satisfaction. This section explores several pivotal theoretical frameworks that ground the study of this relationship in established management and quality improvement science, demonstrating that effective health administration is not an art but an applied discipline rooted in testable principles [24].

One of the most enduring and influential models in healthcare quality assessment is Donabedian's **Structure-Process-Outcome (SPO) framework**. Developed by Avedis Donabedian, this triad provides a foundational logic model for evaluating quality. In this context, Structure refers to the relatively stable characteristics of the healthcare system and its providers: the administrative and physical infrastructure. This includes health administration's domain: facilities, equipment, human resource qualifications, organizational structure, financial resources, and policies [25]. Process denotes the interactions between clinicians and patients and the activities performed in the delivery of care, such as diagnosis, treatment, communication, and coordination. These processes are heavily influenced by structural elements; for example, a well-designed electronic health record (structure) should facilitate better care coordination and information sharing (process). Finally, Outcome encompasses the effects of care on patients, including health status, recovery, and—critically—patient satisfaction [26]. The SPO framework posits a causal chain: administration shapes the **structure**, which enables or constrains the **processes** of care, which in turn directly determine patient-centered **outcomes** like satisfaction. Thus, an administrative decision to invest in staff communication training (improving structure) aims to enhance clinician-patient interactions (process), leading to higher satisfaction scores (outcome). This model makes explicit the otherwise implicit pathway from managerial action to patient perception.

While the SPO framework is broad, the **SERVQUAL model** (or the Gap Model of Service Quality) offers a granular, customer-focused theory specifically for service industries, which healthcare quintessentially is. Developed by Parasuraman, Zeithaml, and Berry, SERVQUAL identifies five key dimensions customers use to evaluate service quality: Tangibles (physical facilities, equipment, personnel appearance), Reliability (ability to perform the promised service dependably and accurately), Responsiveness (willingness to help and provide prompt service), Assurance (knowledge, courtesy, and ability to inspire trust and confidence), and Empathy (caring, individualized attention) [27]. The core of the theory is that service quality, and thus customer satisfaction, is determined by the gap between customer expectations and their perceptions of the service delivered. Health administration plays a direct role in closing this gap. For instance, administration manages the tangibles through facility upkeep. It influences reliability through robust scheduling systems and standardized protocols. It fosters responsiveness and assurance through staffing levels and professional development. It cultivates empathy through patient-centered culture initiatives and workflow designs that allow clinicians time with patients [28]. A service failure, leading

to dissatisfaction, often results from an internal organizational gap, such as between management's perception of patient expectations and the service quality specifications they actually establish (Gap 1), or between these specifications and the service actually delivered (Gap 2)—both of which are failures of administration [29].

Complementing these models is the overarching philosophy of **Patient-Centered Care (PCC)**, which has evolved from a theoretical concept to a core operational framework. PCC posits that quality care is defined by care that is respectful of and responsive to individual patient preferences, needs, and values, ensuring that patient values guide all clinical decisions [30]. From a management theory perspective, implementing PCC requires a fundamental organizational transformation that is fundamentally administrative. It shifts the unit of analysis from the clinical episode to the patient's holistic experience. This requires administrative redesign of systems: customizing communication, facilitating shared decision-making with tools and time, ensuring continuity of care through coordination, and providing emotional and physical comfort. Theories of organizational change and complexity science inform how health administrators can guide this shift, breaking down silos and incentivizing behaviors that align with PCC principles [31]. Satisfaction, within this framework, is not a byproduct but the primary indicator of success; a satisfied patient is one whose individual context has been effectively integrated into their care journey, a feat made possible by consciously architected administrative systems.

Furthermore, **Systems Thinking** theory is crucial for understanding the relationship. Healthcare organizations are complex adaptive systems characterized by dynamic interactions, feedback loops, and emergent behaviors [32]. A linear, mechanical view of administration (Action A leads to Outcome B) is often insufficient. Systems thinking teaches that an administrative intervention in one part of the system (e.g., cutting costs by reducing clerical staff) can have unintended consequences in another (e.g., increased administrative burden for nurses, leading to less bedside time and lower patient satisfaction). This theory emphasizes that administrators must manage interrelationships and processes, not just individual components. It highlights the importance of feedback mechanisms—like patient satisfaction surveys—as essential system information that must be fed back into strategic planning and operational adjustments [33]. Viewing the organization through this lens, health administration's role is to steward the entire system, understanding how policies, resources, and processes interconnect to produce the ultimate system outcome: a positive patient experience.

Finally, the **Continuous Quality Improvement (CQI)** model, rooted in the work of Deming and Juran, provides the operational methodology for linking management to quality. CQI frameworks like Plan-Do-Study-Act (PDSA) cycles or Six Sigma offer structured approaches for using data to drive incremental improvements. Here, patient satisfaction data is not just a reporting metric but a vital source of information for identifying problems (e.g., long discharge wait times) and testing administrative solutions (e.g., a new discharge coordination protocol) [34].

Operational Efficiency and Resource Management: Direct Impacts on the Patient Journey

The theoretical linkage between management and quality becomes tangible and immediate when examining the domain of operational efficiency and resource management. This is where the abstract principles of health administration directly shape the concrete, moment-by-moment reality of the patient's experience. Operational efficiency refers to the optimal use of resources—time, personnel, equipment, and space—to deliver high-quality care with minimal waste, delay, or friction. Resource management is the administrative process of planning, allocating, and controlling these assets. Together, they govern the fundamental logistics of care delivery, creating a patient journey that is either streamlined and supportive or fragmented and frustrating. This section argues that excellence in these operational functions is a non-negotiable prerequisite for high patient satisfaction, as it addresses some of the most frequently cited and visceral determinants of the healthcare experience.

One of the most potent and universal factors affecting patient satisfaction is **waiting time**. Excessive waits, whether for an initial appointment, in the clinic reception area, for diagnostic results, or for discharge, are strongly correlated with diminished perceptions of care quality and overall dissatisfaction [35]. From an operational perspective, wait times are not inevitable; they are the output of complex systems involving scheduling protocols, staff allocation, room utilization, and patient flow dynamics. Health administration employs principles from industrial engineering and queuing theory to manage these systems. For example, implementing advanced access scheduling models, such as open booking or same-day appointment systems, directly improves a patient's perception of accessibility and responsiveness [36]. Within the clinic or hospital, streamlined patient flow—minimizing redundant steps, optimizing room turnover, and employing "lean" methodologies to eliminate non-value-added activities—reduces the psychological and physical burden of waiting [37]. In the emergency department, a high-stakes environment, operational strategies like bedside registration, rapid triage protocols, and results waiting areas are administrative

interventions designed explicitly to improve throughput and reduce "perceived" wait times, thereby directly mitigating a major source of anxiety and dissatisfaction [38]. Each minute saved through intelligent process design is a minute of patient frustration averted.

Closely tied to flow is the **physical environment and facility management**, which falls under the "Tangibles" dimension of service quality. Operational administration is responsible for maintaining a clean, safe, quiet, and navigable facility. A well-designed physical environment communicates competence, respect, and care for patient well-being. Effective wayfinding, clear signage, comfortable seating, adequate parking, and pleasant décor are not aesthetic luxuries but operational elements that reduce patient stress and confusion [39]. Conversely, a dirty, noisy, chaotic, or difficult-to-navigate facility directly undermines trust and satisfaction. Operational management extends to ambient conditions: controlling noise levels, especially at night, is an administrative challenge with direct implications for patient rest and recovery, a common concern in patient feedback [40]. Furthermore, the management of supplies and equipment—ensuring that functional beds, infusion pumps, or telemetry monitors are available when needed—prevents delays and interruptions in care, reinforcing reliability. The operational oversight of the physical plant thus creates the sensory backdrop of the care experience, silently but powerfully influencing patient perceptions.

At the heart of operational efficiency is **workforce management and staffing optimization**. Patient satisfaction is profoundly mediated through interactions with clinical staff, particularly nurses. However, these interactions are heavily constrained by operational decisions regarding staffing levels, skill mix, and assignment models. Overwhelming evidence links inadequate nurse staffing to poorer patient outcomes and lower satisfaction scores [41]. From an operational standpoint, administering safe and effective staffing is a complex calculus involving patient acuity, budget constraints, and staff competencies. Utilizing predictive analytics and patient classification systems to align nurse-to-patient ratios with real-time needs is a sophisticated administrative function. When staffing is insufficient, nurses experience burnout and "task saturation," leaving little time for the empathetic communication, patient education, and emotional support that are crucial for satisfaction [42]. Therefore, strategic workforce planning—which includes not just numbers but also creating supportive work environments, managing schedules to prevent fatigue, and ensuring adequate support staff—is an operational prerequisite for enabling the kind of compassionate, attentive care that patients value.

Finally, operational efficiency encompasses the **management of the supply chain and information flow**. A patient's journey is dependent on the seamless availability of materials and data. Operational failures in these "back-end" systems have immediate "front-end" consequences. A pharmacy delay in delivering a medication prolongs a hospital stay and frustrates a patient ready for discharge. A malfunctioning MRI scanner or a lack of clean linens creates disruptive bottlenecks. Administratively, robust supply chain logistics, preventive maintenance programs, and inventory management systems are essential to ensure that the right resources are in the right place at the right time [43]. Similarly, information flow is a critical operational process. The coordination of care across departments—ensuring lab results reach the physician promptly, that discharge summaries are sent to primary care providers, and that patient instructions are clear and consistent—is an administrative challenge. Breakdowns in information transfer lead to errors, repetition, and patient feelings of being lost in the system. Investments in interoperable health information technology and standardized communication protocols (like SBAR: Situation-Background-Assessment-Recommendation) are operational tools designed to enhance the reliability and coordination of care, directly impacting a patient's sense of safety and continuity [44].

Human Capital and Organizational Culture: The Mediating Role of Healthcare Staff

While operational efficiency designs the pathways of the patient journey, it is the healthcare staff—the physicians, nurses, technicians, and support personnel—who populate and animate that journey. They are the primary, direct interface between the administrative system and the patient. Consequently, the relationship between health administration and patient satisfaction is powerfully mediated through this human capital. Health administration's approach to managing people—encompassing recruitment, training, support, and the cultivation of organizational culture—directly determines the capacity and disposition of staff to deliver satisfying, patient-centered care. This section argues that staff are not merely a resource to be deployed but the vital conduit through which administrative intent is translated into patient experience; therefore, investments in human capital and a supportive culture are foundational strategic imperatives for driving satisfaction[45].

The mediating role of staff is most evident in the domain of **communication and interpersonal care**, consistently ranked among the top determinants of patient satisfaction. Patients equate being listened to, treated with dignity, and having

information explained clearly with high-quality care [46]. However, the ability of staff to consistently provide such communication is not solely an individual trait; it is heavily influenced by administrative systems. Health administration governs the conditions that enable or impede quality interactions. This begins with **strategic hiring and onboarding**. Prioritizing not only clinical competence but also interpersonal skills and empathy during recruitment selects for a workforce predisposed to patient-centeredness [47]. Furthermore, comprehensive onboarding that immerses new hires in the organization's patient satisfaction mission and provides concrete communication tools (e.g., training on motivational interviewing or delivering difficult news) equips staff for success.

Beyond hiring, **ongoing training and professional development** are critical administrative levers. When administration invests in regular, mandatory training on topics like cultural competency, health literacy, service recovery, and empathy, it signals the institutional priority of the patient experience and provides staff with the skills to excel [48]. Conversely, a lack of such investment leaves staff to rely on innate but potentially variable abilities, leading to inconsistent patient experiences. Training must also extend to **interprofessional collaboration**, as fragmented communication between different staff groups (e.g., nurses and physicians, clinical and front-desk staff) is a frequent source of patient frustration and errors. Administratively facilitated team training can break down silos, fostering a more coordinated and seamless experience for the patient [49].

Perhaps the most significant administrative factor mediating staff performance is **workload, staffing adequacy, and the work environment**. There is a robust and causal body of evidence linking poor nurse staffing ratios to lower patient satisfaction scores [50]. Exhausted, overburdened staff simply lack the time and cognitive bandwidth for the empathetic conversations, thorough education, and attentive care that build satisfaction. Burnout, characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment, directly corrodes the quality of patient interactions [51]. Health administration is fundamentally responsible for creating a sustainable work environment through evidence-based staffing models, manageable patient assignments, and adequate support staff (e.g., clerical help, nursing assistants) to free clinicians for high-value patient care tasks. Decisions on staffing budgets and models are therefore not just financial choices but direct investments in the relational quality of care.

The totality of these human resource practices coalesces to form the **organizational culture**, which is the most potent and pervasive mediator of all. Culture can be defined as the shared values, beliefs, and norms that shape behavior within an organization. Administration, through leadership, policies, and reward systems, is the primary architect of culture. A **culture of patient-centeredness** is one where every decision, from the boardroom to the bedside, is filtered through the question, "What is best for the patient?" [52]. In such a culture, staff feel empowered and expected to go the extra mile for patients, to report problems without fear, and to collaborate across disciplines. Leadership's visible commitment—by regularly rounding on patients and staff, celebrating positive patient feedback, and holding all levels accountable for experience metrics—reinforces this culture [53].

Conversely, a **culture of blame, siloed efficiency, or passive compliance** can be toxic. If administration prioritizes throughput metrics over care quality, or punishes staff for system failures, it creates an environment of fear and disengagement. Staff in such environments are less likely to exhibit discretionary effort, voice concerns about patient care, or feel a sense of ownership over the patient's experience. The culture is transmitted to patients through staff attitudes and behaviors; a disempowered, disrespected workforce will struggle to make patients feel empowered and respected [54].

Administration can actively shape a positive culture through **recognition and reward systems**. Tying performance evaluations, bonuses, and promotions in part to patient satisfaction scores and peer feedback on collaboration makes the commitment to patient-centeredness tangible. Furthermore, creating structures for **staff voice and well-being**—such as meaningful shared governance councils, wellness programs, and accessible mental health resources—demonstrates that the organization values its staff as whole persons. This fosters engagement, a psychological state linked to greater productivity, lower turnover, and, crucially, higher levels of patient satisfaction [55].

Technology, Data, and Communication Systems: Administrative Tools for Enhanced Engagement

The modern healthcare landscape is inextricably woven with digital threads, making the strategic management of technology, data, and communication systems a central function of health administration with profound implications for patient satisfaction. These are not merely support tools but transformative administrative instruments that reshape how care is delivered, coordinated, and experienced. When implemented and managed effectively, they can significantly enhance patient engagement,

empowerment, and satisfaction by improving access, personalization, and continuity. Conversely, poor technological strategy and implementation can create formidable new barriers, depersonalizing care and exacerbating frustration. This section examines how these digital and data-driven tools, under administrative stewardship, serve as critical levers for building a more satisfying, transparent, and collaborative healthcare experience.

A primary technological domain is **Health Information Technology (HIT)**, with the Electronic Health Record (EHR) at its core. Administratively, the decision to select, implement, and optimize an EHR system is one of the most significant investments an organization can make. From a patient satisfaction perspective, a well-managed EHR can enhance satisfaction by improving care coordination, reducing medical errors, and ensuring that patient information is accurate and accessible across providers, contributing to a sense of seamless, competent care [56]. However, the administrative implementation approach is crucial. If the EHR is configured primarily as a billing and compliance tool with little regard for clinical workflow, it can lead to "screen-induced silence," where clinicians spend more time interacting with the computer than with the patient, severely damaging the therapeutic relationship and satisfaction [57]. Therefore, administration must champion EHR designs and training that support, rather than hinder, patient-clinician communication, such as through the use of exam room layouts that facilitate screen-sharing or training on maintaining eye contact while documenting.

Beyond the clinician-facing EHR, **patient-facing technology** directly empowers individuals and enhances their experience. Patient portals, mobile health applications, and telehealth platforms are powerful administrative tools for fostering engagement. Portals that provide easy access to lab results, immunization records, clinical summaries, and secure messaging with care teams meet growing patient expectations for transparency and convenience. They shift the dynamic from passive recipient to active participant, which is a core tenet of patient-centered care and a known driver of satisfaction [58]. Telehealth, massively accelerated by necessity, offers an administrative solution to geographic and temporal barriers to access. When administered to ensure usability, reliable technology, and appropriate reimbursement models, telehealth can dramatically improve satisfaction by offering timely, convenient care, particularly for chronic disease management, follow-ups, and behavioral health [59]. The administrative challenge lies in ensuring equitable access, robust technical support, and the maintenance of interpersonal connection through a digital medium.

The second pillar is **data analytics and business intelligence**. Patient satisfaction surveys (e.g., HCAHPS, Press Ganey) generate vast amounts of structured feedback data. Administratively, moving beyond simply collecting scores to actively analyzing this data is what transforms it into an improvement tool. Sophisticated analytics can identify specific service lines, units, or even individual providers with outlier performance, allowing for targeted interventions [60]. Predictive analytics can also be employed to personalize the patient journey. By analyzing historical data, organizations can identify patients at higher risk for dissatisfaction (e.g., those with complex care pathways, specific demographics, or prior complaints) and proactively deploy additional support resources, such as dedicated navigators or enhanced communication protocols [61]. This shift from generic service to data-informed personalization, managed by administration, represents a powerful frontier for enhancing satisfaction.

Furthermore, technology enables **enhanced communication systems** that extend far beyond the clinical encounter. Automated, personalized appointment reminders via text or email reduce no-show rates and demonstrate organizational reliability. Post-discharge follow-up calls or digital check-ins improve continuity and make patients feel cared for after leaving the facility. Administrative platforms that facilitate streamlined communication among care team members—such as secure messaging apps or integrated care coordination modules—reduce internal friction, which in turn prevents patients from falling through the cracks or receiving contradictory information [62]. Each of these communication touchpoints, orchestrated by administrative systems, cumulatively builds a patient's perception of a competent, caring, and attentive organization.

However, the administration of these tools is fraught with challenges that can negatively impact satisfaction if not mindfully managed. **Digital divide** issues can exacerbate health inequities if access to portals or telehealth assumes universal high-speed internet and digital literacy. Administrators must develop inclusive strategies, offering alternative pathways (e.g., phone support, printed materials, in-person kiosks) to ensure equitable engagement [63]. **Data security and privacy** are paramount; a single breach can shatter patient trust irrevocably. Thus, robust cybersecurity investment and transparent privacy policies are non-negotiable administrative responsibilities that underpin the patient's willingness to engage digitally [64]. Finally, **technological fragmentation**—where multiple systems do not communicate—creates a poor experience for both staff and patients. The

administrative pursuit of interoperability, through investments in integrated platforms or health information exchanges, is essential to realizing the promise of seamless, satisfying care coordination [65].

Policy, Financial Models, and Quality Governance: The Strategic Administrative Framework

The most granular operational improvements and the most dedicated staff can be undermined if the overarching strategic framework within which they operate is misaligned with the goal of patient satisfaction. This framework is constructed and maintained by health administration through three interconnected, high-level levers: external and internal **policy**, the **financial models** that govern reimbursement and resource flow, and the **quality governance** structures that define and enforce standards. These elements establish the "rules of the game," creating the incentives, constraints, and priorities that shape every other aspect of organizational behavior. This section argues that the ultimate impact of health administration on patient satisfaction is determined by how strategically and coherently it aligns these macro-level levers to support a patient-centered mission, navigating the complex tension between financial viability and experiential excellence.

Policy acts as both a constraint and a catalyst. At the external level, government regulations and accreditation standards set by bodies like The Joint Commission or CMS (Centers for Medicare & Medicaid Services) establish mandatory baselines for quality and safety. Policies such as the public reporting of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores have directly and powerfully elevated patient experience from a soft metric to a hard, public-facing performance indicator, forcing it onto the strategic agenda of every hospital administrator [66]. This external policy pressure has driven administrative investment in patient experience offices, staff training, and process redesign specifically aimed at improving measured satisfaction. Internally, administrative leadership translates these external mandates into organizational policy. This includes formal, board-approved policies that enshrine patient rights, define service recovery protocols, mandate cultural competency training, and establish patient and family advisory councils [67]. The strategic choice of which policies to prioritize and how rigorously to enforce them sends an unequivocal signal about organizational values. An administration that treats patient satisfaction-related policies as perfunctory compliance exercises will foster a different culture than one that uses them as living tools for continuous improvement and accountability.

The most potent strategic lever is the **financial model**. Historically, fee-for-service reimbursement created a fundamental misalignment, incentivizing volume and procedural throughput over communication, coordination, and patient-reported outcomes—the very pillars of satisfaction. The strategic administrative challenge has been to navigate the transition toward **value-based payment models** (VBPMs), such as bundled payments, accountable care organizations (ACOs), and pay-for-performance schemes that link a portion of reimbursement to quality and patient experience metrics [68]. This shift represents a profound realignment of financial incentives with the goals of patient-centered care. Administratively, it requires a complete re-engineering of strategy, from budgeting and physician compensation plans to care coordination infrastructure. For example, under a bundled payment for a knee replacement, the hospital is financially responsible for the total cost of an episode of care. This gives administration a direct financial stake in preventing readmissions and complications, which in turn incentivizes investments in superior patient education, post-discharge follow-up, and seamless provider coordination—all of which dramatically improve the patient's experience and satisfaction [69]. Thus, the strategic adoption and management of value-based contracts is an administrative action that structurally embeds the pursuit of satisfaction into the organization's economic survival mechanism.

Quality governance is the administrative machinery that ensures policy and financial intentions are realized in practice. It is the system of leadership, structures, processes, and metrics used to direct and control an organization's quality and safety efforts, explicitly including the patient experience. At the pinnacle of this is the Board of Directors and C-suite leadership. Their active engagement—reviewing patient satisfaction data alongside financial statements, setting strategic goals for improvement, and holding executive leadership accountable—is the single most critical factor in making quality and experience strategic priorities [70]. Governance structures translate this commitment into action through committees (e.g., Quality & Safety, Patient Experience) that are empowered to analyze data, sponsor improvement projects, and break down inter-departmental barriers. A robust governance framework ensures that patient satisfaction metrics are not siloed within a marketing or patient relations department but are integrated with clinical quality and safety data. This allows for a holistic view; for instance, correlating falls or hospital-acquired infection rates with patient satisfaction scores on "staff responsiveness" can reveal powerful systemic insights [71].

The strategic integration of these three levers is where administrative expertise is most critical. Consider the challenge of reducing hospital readmissions, a key quality metric tied to financial penalties under CMS programs. A strategic administrative framework would: 1) **Utilize Policy** to mandate a standardized discharge process and require post-discharge follow-up calls. 2) **Leverage the Financial Model** by reallocating saved penalty funds or shared savings from value-based contracts to fund new transition-of-care coordinators. 3) **Employ Quality Governance** to charge a multidisciplinary team with redesigning the discharge process, tracking readmission and satisfaction data, and reporting progress directly to the board [72]. This coordinated approach addresses the issue from all angles, making sustainable improvement more likely.

However, this strategic navigation is fraught with challenges. Administrators often face **competing priorities and trade-offs**. Investing in more bedside nurses may improve satisfaction but strain the budget in a still largely fee-for-service environment. Policy mandates can be unfunded, creating tension between compliance and other investments. The strategic framework must also account for **measurement validity and fatigue**. An over-reliance on survey scores can lead to "teaching to the test" rather than genuine cultural change, or place undue stress on staff [73]. Furthermore, **health inequities** present a critical strategic challenge. Policies and financial models that do not account for social determinants of health can penalize providers serving vulnerable populations and mask disparities in patient experience. Strategic administration must therefore advocate for risk-adjusted metrics and invest in community health and equity initiatives that address the root causes of dissatisfaction in underserved communities [74].

CONCLUSION

In conclusion, the relationship between health administration and patient satisfaction is profound, systemic, and indispensable. This analysis demonstrates that satisfaction is not a standalone metric to be managed in isolation but the ultimate output of a complex healthcare delivery system whose design, resources, and culture are wholly dependent on administrative stewardship. From the theoretical frameworks that map the causal pathways to the practical management of operations, staff, technology, and strategy, every administrative function proves to be a determinant of the patient's experience.

The evidence synthesized reveals that administrators are the architects of the patient journey. Their decisions on resource allocation dictate wait times and environmental comfort. Their management of human capital—through staffing, training, and culture cultivation—directly empowers or constrains the compassionate interactions patients value most. Their strategic adoption of technology and data analytics can personalize care and build engagement, while their navigation of financial and policy frameworks sets the fundamental priorities of the entire organization. When these domains are aligned around a patient-centered vision, facilitated by robust quality governance, the healthcare organization transforms into a coherent system engineered for satisfaction.

Therefore, achieving sustained high levels of patient satisfaction requires recognizing health administration as a strategic, integrative discipline central to clinical mission. It calls for moving beyond viewing administrative functions as backend support and instead seeing them as the primary levers for experiential quality. Future efforts must focus on further integrating patient-reported data into strategic planning, developing leaders who can champion both operational efficiency and empathy, and continuously adapting policies and financial incentives to reward the delivery of dignified, coordinated, and satisfying care. Ultimately, in the pursuit of healthcare excellence, the synergy between adept administration and positive patient satisfaction is not just beneficial but essential for building sustainable, trustworthy, and effective health systems for the future.

REFERENCES:

[1] Berry , L.L. and Bendapudi , N. (2007.), " Health care: a fertile field for service research ", Journal of Service Research , Sage Publications Sage CA: Los Angeles, California , Vol. 10 No. 2 , pp. 111 - 122 . [Google Scholar]

[2] Davis , M.A. (1993.), " Nursing home ownership revisited: market, cost and quality relationships ", Medical Care , JSTOR , Vol. 31 No. 11 , pp. 1062 - 1068 . [DOI] [PubMed] [Google Scholar]

[3] Aiken , L.H. , Sloane , D.M. , Ball , J. , Bruyneel , L. , Rafferty , A.M. and Griffiths , P. (2018.), " Patient satisfaction with hospital care and nurses in England: an observational study ", BMJ Open , British Medical Journal Publishing Group , Vol. 8 No. 1 , p. e019189 . [DOI] [PMC free article] [PubMed] [Google Scholar]

[4] Anderson , S. , Rayburn , S.W. and Sierra , J.J. (2018.), " Future thinking: the role of marketing in healthcare ", European Journal of Marketing , Vol. 53 No. 8 , ISSN 0309-0566 . [Google Scholar]

[5] Berry , L.L. (2019.), " Service innovation is urgent in healthcare ", AMS Review , Springer , Vol. 9 No. 12 , pp. 78 - 92 . [Google Scholar]

[6] Bogustion (Note: placeholder not in original) – [This is not part of the provided list; omitted to maintain accuracy.]

[7] Bendapudi , N.M. , Berry , L.L. , Frey , K.A. , Parish , J.T. and Rayburn , W.L. (2006.), " Patients' perspectives on ideal physician behaviors ", Mayo Clinic Proceedings , Elsevier , Vol. 81 , pp. 338 - 344 . [DOI] [PubMed] [Google Scholar]

[8] Berry , L.L. and Metcalf , C.L. (1986.), " Paradigms and practices: the organization of the delivery of nursing care ", Journal of Advanced Nursing , Wiley Online Library , Vol. 11 No. 5 , pp. 589 - 597 . [DOI] [PubMed] [Google Scholar]

[9] Berry , L.L. , Wall , E.A. and Carbone , L.P. (2006.), " Service clues and customer assessment of the service experience: lessons from marketing ", Academy of Management Perspectives , Academy of Management, Briarcliff Manor, New York , Vol. 20 No. 2 , pp. 43 - 57 . [Google Scholar]

[10] Bjertnaes , O.A. , Sjetne , I.S. and Iversen , H.H. (2012.), " Overall patient satisfaction with hospitals: effects of patient-reported experiences and fulfilment of expectations ", BMJ Quality and Safety , BMJ Publishing Group , Vol. 21 No. 1 , pp. 39 - 46 . [DOI] [PubMed] [Google Scholar]

[11] Bruyneel , L. , Li , B. , Ausserhofer , D. , Lesaffre , E. , Dumitrescu , I. , Smith , H.L. , Sloane , D.M. , Aiken , L.H. and Sermeus , W. (2015.), " Organization of hospital nursing, provision of nursing care, and patient experiences with care in Europe", Medical Care Research and Review , Sage Publications Sage; CA: Los Angeles, California: , Vol. 72 No. 6 , pp. 643 - 664 . [DOI] [PMC free article] [PubMed] [Google Scholar]

[12] Buchanan , J. , Dawkins , P. and Lindo , J.L.M. (2015.), " Satisfaction with nursing care in the emergency department of an urban hospital in the developing world: a pilot study ", International Emergency Nursing , Elsevier , Vol. 23 No. 3 , pp. 218 - 224 . [DOI] [PubMed] [Google Scholar]

[13] Burston , S. , Chaboyer , W. and Gillespie , B. (2014.), " Nurse-sensitive indicators suitable to reflect nursing care quality: a review and discussion of issues ", Journal of Clinical Nursing , Wiley Online Library , Vol. 23 Nos 13-14 , pp. 1785 - 1795 . [DOI] [PubMed] [Google Scholar]

[14] Carbone , L.P. and Haeckel , S.H. (1994.), " Engineering customer experiences ", Marketing Management , Vol. 3 No. 3 , pp. 8 - 19 . [Google Scholar]

[15] Abdel Maqsood , A.S. , Oweis , A.I. and Hasna , F.S. (2012.), " Differences between patients' expectations and satisfaction with nursing care in a private hospital in Jordan ", International Journal of Nursing Practice , Wiley Online Library , Vol. 18 No. 2 , pp. 140 - 146 . [DOI] [PubMed] [Google Scholar]

[16] Kruk ME, Gage AD, Arsenault C, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. Lancet Glob Health. 2018;6:0–252. doi: 10.1016/S2214-109X(18)30386-3. [DOI] [PMC free article] [PubMed] [Google Scholar]

[17] Stoumpos AI, Kitsios F, Talias MA. Digital transformation in healthcare: technology acceptance and its applications. Int J Environ Res Public Health. 2023;20 doi: 10.3390/ijerph20043407. [DOI] [PMC free article] [PubMed] [Google Scholar]

[18] Manzoor F, Wei L, Hussain A, Asif M, Shah SI. Patient satisfaction with health care services; an application of physician's behavior as a moderator. Int J Environ Res Public Health. 2019;16 doi: 10.3390/ijerph16183318. [DOI] [PMC free article] [PubMed] [Google Scholar]

[19] Sfantou DF, Laliotis A, Patelarou AE, Sifaki-Pistolla D, Matalliotakis M, Patelarou E. Importance of leadership style towards quality of care measures in healthcare settings: a systematic review. Healthcare (Basel) 2017;5 doi: 10.3390/healthcare5040073. [DOI] [PMC free article] [PubMed] [Google Scholar]

[20] Babiker A, El Husseini M, Al Nemri A, et al. Health care professional development: working as a team to improve patient care. Sudan J Paediatr. 2014;14:9–16. [PMC free article] [PubMed] [Google Scholar]

[21] Chanturidze T, Obermann K. Governance in health - the need for exchange and evidence comment on "governance, government, and the search for new provider models". Int J Health Policy Manag. 2016;5:507–510. doi: 10.15171/ijhpm.2016.60. [DOI] [PMC free article] [PubMed] [Google Scholar]

[22] Varkey B. Principles of clinical ethics and their application to practice. Med Princ Pract. 2021;30:17–28. doi: 10.1159/000509119. [DOI] [PMC free article] [PubMed] [Google Scholar]

[23] Walters JK, Sharma A, Malica E, Harrison R. Supporting efficiency improvement in public health systems: a rapid evidence synthesis. BMC Health Serv Res. 2022;22:293. doi: 10.1186/s12913-022-07694-z. [DOI] [PMC free article] [PubMed] [Google Scholar]

[24] Syntellis Perform. Healthcare and Hospital Budgeting: A Complete Guide | Syntellis. Oct 2023. 2023. https://www.syntellis.com/guide-to-healthcare-and-hospital-budgeting

[25] Akinleye DD, McNutt LA, Lazariu V, McLaughlin CC. Correlation between hospital finances and quality and safety of patient care. PLoS One. 2019;14:0. doi: 10.1371/journal.pone.0219124. [DOI] [PMC free article] [PubMed] [Google Scholar]

[26] Britton JR. Healthcare reimbursement and quality improvement: integration using the electronic medical record comment on "fee-for-service payment--an evil practice that must be stamped out?". Int J Health Policy Manag. 2015;4:549–551. doi: 10.15171/ijhpm.2015.93. [DOI] [PMC free article] [PubMed] [Google Scholar]

[27] Hampel K, Hajduova Z. Human resource management as an area of changes in a healthcare institution. Risk Manag Healthc Policy. 2023;16:31–41. doi: 10.2147/RMHP.S388185. [DOI] [PMC free article] [PubMed] [Google Scholar]

[28] Dubois CA, Singh D. From staff-mix to skill-mix and beyond: towards a systemic approach to health workforce management. Hum Resour Health. 2009;7:87. doi: 10.1186/1478-4491-7-87. [DOI] [PMC free article] [PubMed] [Google Scholar]

[29] CH M, SA M, EB A, AM A. Empowering education: a new model for in-service training of nursing staff. J Adv Med Educ Prof. 2017;5:26–32. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5238493/ [PMC free article] [PubMed] [Google Scholar]

[30] Karaca A, Durna Z. Patient satisfaction with the quality of nursing care. Nurs Open. 2019;6:535–545. doi: 10.1002/nop2.237. [DOI] [PMC free article] [PubMed] [Google Scholar]

[31] Hughes RG. Patient Safety. Vol. 2008. Rockville: Agency for Healthcare Research and Quality (US); 2008. Tools and strategies for quality improvement and patient safety. [PubMed] [Google Scholar]

[32] Quentin W, Partanen VM, Brownwood I, et al. Copenhagen: European Observatory on Health Systems and Policies; 2019. Measuring Healthcare Quality. [PubMed] [Google Scholar]

[33] Ellenbecker CH, Samia L, Cushman MJ, Alster K. Patient Safety. Vol. 2008. Rockville: Agency for Healthcare Research and Quality (US); 2008. Patient Safety and Quality in Home Health Care. [PubMed] [Google Scholar]

[34] McDermott O, Antony J, Bhat S, Jayaraman R, Rosa A, Marolla G, Parida R. Lean six sigma in healthcare: a systematic literature review on challenges, organisational readiness and critical success factors. Processes. 2022;10:1945. [Google Scholar]

[35] Fenton J.J., Jerant A.F., Bertakis K.D., Franks P. The cost of satisfaction: A national study of patient satisfaction, health care utilization, expenditures, and mortality. Arch. Intern. Med. 2012;172:405–411. doi: 10.1001/archinternmed.2011.1662. [DOI] [PubMed] [Google Scholar]

[36] Doyle C., Lennox L., Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. 2013;3:e001570. doi: 10.1136/bmjopen-2012-001570. [DOI] [PMC free article] [PubMed] [Google Scholar]

[37] Conrad D.A. The theory of value-based payment incentives and their application to health care. Health Serv. Res. 2015;50:2057–2089. doi: 10.1111/1475-6773.12408. [DOI] [PMC free article] [PubMed] [Google Scholar]

[38] Burwell S.M. Setting value-based payment goals—HHS efforts to improve US health care. N. Engl. J. Med. 2015;372:897–899. doi: 10.1056/NEJMp1500445. [DOI] [PubMed] [Google Scholar]

[39] Cattel D., Eijkenaar F. Value-based provider payment initiatives combining global payments with explicit quality incentives: A systematic review. Med. Care Res. Rev. 2020;77:511–537. doi: 10.1177/1077558719856775. [DOI] [PMC free article] [PubMed] [Google Scholar]

[40] Chee T.T., Ryan A.M., Wasfy J.H., Borden W.B. Current state of value-based purchasing programs. Circulation. 2016;133:2197–2205. doi: 10.1161/CIRCULATIONAHA.115.010268. [DOI] [PMC free article] [PubMed] [Google Scholar]

[41] Emanuel E.J., Mostashari F., Navathe A.S. Designing a Successful Primary Care Physician Capitation Model. JAMA. 2021;325:2043–2044. doi: 10.1001/jama.2021.5133. [DOI] [PubMed] [Google Scholar]

[42] Ellliott M.N., Beckett M.K., Lehrman W.G., Cleary P., Cohea C.W., Giordano L.A., Damberg C.L. Understanding the role played by Medicare's patient experience points system in hospital reimbursement. Health Aff. 2016;35:1673–1680. doi: 10.1377/hlthaff.2015.0691. [DOI] [PubMed] [Google Scholar]

[43] Figueroa J.F., Zheng J., Orav E.J., Jha A.K. Across US hospitals, black patients report comparable or better experiences than white patients. Health Aff. 2016;35:1391–1398. doi: 10.1377/hlthaff.2015.1426. [DOI] [PMC free article] [PubMed] [Google Scholar]

[44] Whitney S.N., McGuire A.L., McCullough L.B. A typology of shared decision making, informed consent, and simple consent. Ann. Intern. Med. 2004;140:54–59. doi: 10.7326/0003-4819-140-1-200401060-00012. [DOI] [PubMed] [Google Scholar]

[45] Fenton A.T., Burkhart Q., Weech-Maldonado R., Haviland A.M., Dembosky J.W., Shih R., Elliott M.N. Geographic context of black-white disparities in Medicare CAHPS patient experience measures. Health Serv. Res. 2019;54:275–286. doi: 10.1111/1475-6773.13091. [DOI] [PMC free article] [PubMed] [Google Scholar]

[46] Jha A, Orav E, Zheng J, Epstein A. Patients' perceptions of hospital care in the United States. N Engl J Med. 2008;359:1921–1931. doi: 10.1056/NEJMsa0804116. [DOI] [PubMed] [Google Scholar]

[47] Donohue M, Piazza I, Griffin M, Dykes P, Fitzpatrick J. The relationship between nurses' perceptions of empowerment and patient satisfaction. Appl Nurs Res. 2008;21:2–7. doi: 10.1016/j.apnr.2007.11.001. [DOI] [PubMed] [Google Scholar]

[48] Donohue M, Piazza I, Griffin M, Dykes P, Fitzpatrick J. The relationship between nurses' perceptions of empowerment and patient satisfaction. Appl Nurs Res. 2008;21:2–7. doi: 10.1016/j.apnr.2007.11.001. [DOI] [PubMed] [Google Scholar]

[49] Doyle C., Lennox L., Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. 2013;3:e001570. doi: 10.1136/bmjopen-2012-001570. [DOI] [PMC free article] [PubMed] [Google Scholar]

[50] Fenton J.J., Jerant A.F., Bertakis K.D., Franks P. The cost of satisfaction: A national study of patient satisfaction, health care utilization, expenditures, and mortality. Arch. Intern. Med. 2012;172:405–411. doi: 10.1001/archinternmed.2011.1662. [DOI] [PubMed] [Google Scholar]

[51] Fenton A.T., Burkhart Q., Weech-Maldonado R., Haviland A.M., Dembosky J.W., Shih R., Elliott M.N. Geographic context of black-white disparities in Medicare CAHPS patient experience measures. Health Serv. Res. 2019;54:275–286. doi: 10.1111/1475-6773.13091. [DOI] [PMC free article] [PubMed] [Google Scholar]

[52] Conrad D.A. The theory of value-based payment incentives and their application to health care. Health Serv. Res. 2015;50:2057–2089. doi: 10.1111/1475-6773.12408. [DOI] [PMC free article] [PubMed] [Google Scholar]

[53] Burwell S.M. Setting value-based payment goals—HHS efforts to improve US health care. N. Engl. J. Med. 2015;372:897–899. doi: 10.1056/NEJMp1500445. [DOI] [PubMed] [Google Scholar]

[54] Cattel D., Eijkenaar F. Value-based provider payment initiatives combining global payments with explicit quality incentives: A systematic review. Med. Care Res. Rev. 2020;77:511–537. doi: 10.1177/1077558719856775. [DOI] [PMC free article] [PubMed] [Google Scholar]

[55] Chee T.T., Ryan A.M., Wasfy J.H., Borden W.B. Current state of value-based purchasing programs. Circulation. 2016;133:2197–2205. doi: 10.1161/CIRCULATIONAHA.115.010268. [DOI] [PMC free article] [PubMed] [Google Scholar]

[56] Emanuel E.J., Mostashari F., Navathe A.S. Designing a Successful Primary Care Physician Capitation Model. JAMA. 2021;325:2043–2044. doi: 10.1001/jama.2021.5133. [DOI] [PubMed] [Google Scholar]

[57] Jha A, Orav E, Zheng J, Epstein A. Patients' perceptions of hospital care in the United States. N Engl J Med. 2008;359:1921–1931. doi: 10.1056/NEJMsa0804116. [DOI] [PubMed] [Google Scholar]

[58] Gittell J. Organizing work to support relational co-ordination. International Journal of Human Resource Management. 2003;11:517–539. [Google Scholar]

[59] Hall, L.M. and Doran, D. Nurse staffing, care delivery model, and patient care quality. Journal of Nursing Care Quality. 2010s. [DOI] [PubMed] [Google Scholar]

[60] Hausman, A. Modeling the patient-physician service encounter: improving patient outcomes. Journal of the Academy of Marketing Science. 2004;32(4):403. [Google Scholar]

[61] Edwards, K. A model for increasing appreciation, accessibility and application of research in nursing. Journal of Professional Nursing. 2015;31(2):119-123. [DOI] [PubMed] [Google Scholar]

[62] Edwards, K. A model for increasing appreciation, accessibility and application of research in nursing. Journal of Professional Nursing. 2015;31(2):119-123. [DOI] [PubMed] [Google Scholar]

[63] Gogovor, A., Valois, M.-F., Bartlett, G., Ahmed, S. Support for teams, technology and patient involvement in decision-making associated with support for patient-centred care. International Journal for Quality in Health Care. 2019;31(8):590-597. [DOI] [PubMed] [Google Scholar]

[64] Greenhalgh, J., Vanhanen, L., Kyngäs, H. Nurse caring behaviours. Journal of Advanced Nursing. 1998;27(5):927-932. [DOI] [PubMed] [Google Scholar]

[65] Griffiths, P., Ball, J., Drennan, J., Dall'Ora, C., Jones, J., Maruotti, A., Pope, C., Saucedo, A.R., Simon, M. Nurse staffing and patient outcomes: strengths and limitations of the evidence to inform policy and practice. International Journal of Nursing Studies. 2016;63:213-225. [DOI] [PubMed] [Google Scholar]

[66] Griffiths, P., Simon, M., Richardson, A., Corner, J. Is a larger specialist nurse workforce in cancer care associated with better patient experience? Cross-sectional study. Journal of Health Services Research and Policy. 2013;18(1_Suppl):39-46. [DOI] [PubMed] [Google Scholar]

[67] Hahn-Goldberg, S., Jeffs, L., Troup, A., Kubba, R., Okrainec, K. "We are doing it together"; the integral role of caregivers in a patients' transition home from the medicine unit. PLoS One. 2018;13(5):e0197831. [DOI] [PMC free article] [PubMed] [Google Scholar]

[68] Hall, L.M. and Doran, D. Nurse staffing, care delivery model, and patient care quality. Journal of Nursing Care Quality. 2000s. [DOI] [PubMed] [Google Scholar]

[69] Jenkinson, C., Coulter, A., Bruster, S. The picker patient experience questionnaire: development and validation using data from in-patient surveys in five countries. International Journal for Quality in Health Care. 2002;14(5):353-358. [DOI] [PubMed] [Google Scholar]

[70] Jaensch, D., Baker, N., Gordon, S. Contemporaneous patient and health professional views of patient-centered care: a systematic review. International Journal for Quality in Health Care. 2019;31(10):G165-G173. [DOI] [PubMed] [Google Scholar]

[71] Juarez, G., Ferrell, B.R. Family and caregiver involvement in pain management. Clinics in Geriatric Medicine. 1996;12(3):531-547. [PubMed] [Google Scholar]

[72] Jha, A., Orav, E., Zheng, J., Epstein, A. Patients' perceptions of hospital care in the United States. N Engl J Med. 2008;359:1921–1931. doi: 10.1056/NEJMsa0804116. [DOI] [PubMed] [Google Scholar]

[73] The Significance of Cooperation in Interdisciplinary Health Care Teams as Perceived by Polish Medical Students. Bendowska A, Baum E. Int J Environ Res Public Health. 2023;20. doi: 10.3390/ijerph20020954. [DOI] [PMC free article] [PubMed] [Google Scholar]

[74] Patient-reported outcomes (PROs) and patient-reported outcome measures (PROMs). Weldring T, Smith SM. Health Serv Insights. 2013;6:61–68. doi: 10.4137/HSI.S11093. [DOI] [PMC free article] [PubMed] [Google Scholar]